NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

FEBRUARY 3, 2022
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

Supervisor Katrina Foley, Alternate

CHIEF EXECUTIVE OFFICER (INTERIM)	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Hunn	Gary Crockett	Sharon Dwiers

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

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

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

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

1) **Listen to the live audio at or +1 (415) 655-0060 and Access Code: 836-688-680 or**
2) **Participate via Webinar at** https://attendee.gotowebinar.com/register/3655286632977861 23 **rather than attending in person. Webinar instructions are provided below.**

Regular Meeting of the
CalOptima Board of Directors
February 3, 2022

CALL TO ORDER

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report

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

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the December 20, 2021 Special Meeting of the CalOptima Board of Directors

3. Adopt Board Resolution No. 22-0203-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

4. Authorization to Enter into Negotiations with the County of Orange to Modify and Extend the Current License Agreement for Use of Space at the County Community Service Center Annex

5. Authorize Modification to and Extension of the Contract with Miller Geer & Associates for External Communications Support Services

6. Authorize Actions Related to American Family Housing Casa Paloma Care Coordination

7. Authorization to execute a contract amendment for updated rates related to the CalOptima Multipurpose Senior Services Program (MSSP) Non-Medical Ancillary Fee-For-Service Contract with Kenady Corporation, dba LifeSpring Nutrition for MSSP Home Delivered Meals

8. Authorize Amendment to Contract with Kenady Corporation, dba LifeSpring Nutrition, to Support CalOptima Program of All-Inclusive Care for the Elderly (PACE) Home-Delivered Meals

9. Approval of Modifications to CalOptima Customer Service Policies: DD.2001 and DD.2002

10. Approve Changes to CalOptima Provider Network Policies

11. Approve Modifications to CalOptima Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network Contracted Providers to Require a Medicare Annual Wellness Visit to be Completed

12. Authorize an Amendment to the Veyo LLC Fee-for-Service Ancillary Services Contract to Increase Rates for Select Services Provided to Medi-Cal, OneCare, and OneCare Connect Members

13. Authorize Allocation of Intergovernmental Transfer (IGT) 10 Funds to the Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP)

14. Receive and File:
    a. November and December 2021 Financial Summaries
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

15. Request to Ratify and Extend the Use of a Temporary Utilization Management Protocol for Referrals to University of California, Irvine Specialist Physicians through 2/28/2022.

16. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

17. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

18. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Hospitals, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

19. Authorize Amendments to the CalOptima Community Network Professional Services Contracts to Add OneCare as a Covered CalOptima Program

20. Ratify the Contract with Illumination Foundation for the Provision of Accompaniment Services for Enhanced Care Management (ECM) Under the California Advancing and Innovating Medi-Cal Program (CalAIM); Authorize an Amendment to this Contract; and Authorize Contracts with Other Qualified Accompaniment Services Providers Using the Ancillary Services Contract for Non-Medical Providers Template

21. Authorize Appropriation of Funds, Unbudgeted Expenditures and a Grant Agreement with Mind OC for Intake and Admissions Coordination Services at the Be Well OC Wellness Center Orange Campus

22. Authorize Amendments to the Children's Hospital of Orange County and CHOC Physician Network Contracts for Health Care Services Reflecting Language Regarding its Pediatric Member Population

23. Authorize New and Amended Contracts for ARTA Western California Inc., Monarch HealthCare A Medical Group Inc., and Talbert Medical Group P.C. to Reflect Name Changes

24. Approve Amendment to Heritage Provider Network, Inc.'s. Medi-Cal Health Network Contract for Health Care Services to Specify Requirements and Responsibilities Related to CalOptima's Enhanced Care Management Services, effective January 1, 2022

25. Adopt Resolutions to Authorize the Appointment of Retired Annuitants to the Positions of Interim Chief Medical Officer and Medical Director to carry out the duties and responsibilities of the vacant positions during a public health emergency to mitigate the effects of the COVID-19 pandemic and prevent the stoppage of public business

ADVISORY COMMITTEE UPDATES

26. Special Joint Meeting of the CalOptima Advisory Committees Update

CLOSED SESSION

CS-1. Pursuant to Government Code Section 54957(b) (1): Public Employee Discipline/Dismissal/Release

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

HOW TO JOIN

1. Please register for Special Meeting of the CalOptima Board of Directors on February 3, 2022 2:00 PM PDT at:
   https://attendee.gotowebinar.com/register/3655286632977861 23

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

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:

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

   --OR--

   TO USE YOUR TELEPHONE:

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

   United States: +1 (415) 655-0060

   Access Code: 836-688-680

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	January 27, 2022
TO:	CalOptima Board of Directors
FROM:	Michael Hunn, Chief Executive Officer (Interim)
SUBJECT:	CEO Report — February 3, 2022, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

a. New Chief Medical Officer Joins CalOptima

I am pleased to announce that Richard Pitts, D.O., Ph.D., is joining CalOptima as Chief Medical Officer on February 7. Dr. Pitts has a distinguished career spanning more than 40 years in clinical practice as well as medical group and hospital leadership. His experience also includes state-level positions, serving on the California Industrial Medical Council and as Board President of the California State Licensing Board for six years. Dr. Pitts holds a bachelor's degree in Chemistry from Chapman University, a Doctor of Osteopathic Medicine from Des Moines University and a Ph.D. in Management & Decision Sciences from Walden University.

b. Treatment Authorization (TA) Backlog Cleared

The backlog of TAs, which at one point exceeded 15,000 in December, has now been cleared. Staff will continue to monitor daily inventory and implement a dashboard report to ensure transparency. Going forward, we will focus on long-term improvements to guarantee continued inventory management, efficiencies and concentrate on the right clinical areas for optimal performance. CalOptima's Information Technology Services team has also undertaken a Request for Proposal (RFP) to replace the current clinical management system.

c. Department of Health Care Services (DHCS) Routine, Annual Medi-Cal Audit Begins

The DHCS routine annual medical audit of CalOptima's Medi-Cal program began on January 24 and will end on February 4. It covers the audit review period of February 1, 2020, through December 31, 2021. The audit will evaluate six categories of performance: Utilization Management; Case Management and Coordination of Care; Access and Availability of Care; Member's Rights; Quality Management; and Administrative and Organizational Capacity. Interview sessions will include CalOptima staff as well as representatives from Kaiser, Prospect Medical Group and Family Choice Medical Group, the delegated entities selected to participate in the audit. DHCS will provide the draft report and formal exit conference in April.

d. California Advancing and Innovating Medi-Cal (CalAIM) Off to a Strong Start

On January 1, CalOptima transitioned approximately 2,000 members from the Whole Person Care pilot and the Health Homes Program to the new Enhanced Care Management (ECM) program and Community Supports services. CalOptima continues to actively communicate with providers and community stakeholders about CalAIM, particularly focusing on the referral process for ECM and Community Supports. CalOptima held an informational webinar on

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January 26 to present an update about the launch and offer a forum to provide feedback to more than 400 registered stakeholders. CalOptima also continues to work with DHCS in the implementation and evolution of CalAIM. On January 12, CalOptima submitted our CalAIM Incentive Payment Program for DHCS' consideration and approval. As part of that submission, CalOptima committed to expanding data connectivity between CalAIM providers, increasing the number and diversity of ECM providers, and providing access to all state-approved Community Support services by January 1, 2023.

e. Providers Experience Issues with Medi-Cal Rx Rollout

CalOptima has been communicating to the provider community about Medi-Cal Rx, including the need for them to register with Medi-Cal Rx and receive training. DHCS held a virtual meeting to address provider and pharmacy issues concerning Magellan's call center capacity, claims processing and other items related to the rollout on January 1. In addition, Magellan has added office hours for all Managed Care Plans at least through the end of February to answer questions and identify solutions. They have also offered to host a Q & A session for CalOptima's leadership team to ensure there is open dialog and to address concerns unique to our members. Our Customer Service team continues to respond to member and provider inquiries concerning Medi-Cal Rx and they have handled 1,011 calls since the launch.

f. CalFresh Strategy to Extend Benefits to More Members

CalOptima is collaborating with the County of Orange Social Services Agency (SSA) to raise awareness about CalFresh as part of our effort to address social determinants of health. Staff is preparing a targeted outreach campaign to increase enrollment by 100,000 CalOptima members by December 2022. Details on the strategy and a budget request will be included in a COBAR for your Board's consideration in March.

g. Budgeting Methodologies for FY 2022-2023

CalOptima has begun to prepare next fiscal year's General and Administrative (G&A) budget. Staff will be using a "zero-based" budgeting methodology, which requires departments to justify each expense before adding it to the new budget — even old and recurring expenses. In addition, departments will recognize where each expense fits within the broader context of the agency's CY 2022-2025 strategic priorities and goals, pending approval by the Board. We will be preparing a "balanced operating budget" this year. Any new initiatives that the Board approves in addition to the operating budget, will be 'drawn down' from CalOptima reserves. Staff will recognize, track and report these initiatives to the Board under a separate section on the monthly financials.

h. Gov. Newsom Releases Fiscal Year (FY) 2022–23 Proposed Budget

On January 10, Gov. Gavin Newsom released his FY 2022–23 Proposed State Budget with total spending at $286.4 billion, reflecting an increase of 9.1% when compared with the FY 2021–22 Enacted Budget. Of this, the budget includes overall Medi-Cal spending of $132.7 billion as well as the following proposals that may impact CalOptima:

- $1.5 billion to convert tiny homes into behavioral health bridge housing to address the immediate needs of homeless individuals with serious behavioral health conditions
- Additional funding to support CalAIM initiatives, including local capacity building as well as prerelease Medi-Cal eligibility screenings and 90 days of targeted in-reach services

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- New behavioral health benefits, including dyadic services, 24/7 mobile crisis intervention services and a statewide screening platform
- Expanded Medi-Cal eligibility to beneficiaries ages 26–49, regardless of immigration status, to achieve universal Medi-Cal coverage for all ages no sooner than January 2024.

i. CalOptima, Orange County Health Care Agency Host Additional Vaccine Clinics

In partnership with Orange County Health Care Agency, CalOptima has added COVID-19 vaccine clinics through April. At the clinics, CalOptima staff will distribute $25 Member Health Rewards to eligible members who get their vaccination, and representatives from SSA will encourage enrollment in CalFresh for those who qualify. From CalOptima's first clinic in May 2021 to now, 8,445 community members have received a vaccine. Future clinics are planned for February 19, March 12, March 26, April 9, April 16 and April 23.

j. Mobile Mammography Clinics Aimed at Hard-to-Reach Communities

In 2021, CalOptima conducted a Population Needs Assessment that identified a low incidence of breast cancer screening in the Asian population among Chinese members at 49% and Korean members at 57%. CalOptima is partnering with Alinea Medical Imaging on mobile mammography community events to encourage breast cancer screening among members who are less likely to access this benefit due to cultural or ethnic disparities. The clinics are available to CalOptima Community Network members ages 50–74 who are due to complete a breast cancer screening. Two clinics were completed on January 19 and February 2. Additional events are planned for February 16 in Anaheim and April 16 in Costa Mesa.

k. CalOptima Gains Significant Media Coverage

- On December 21, Kaiser Health News posted an article about the challenges Medi-Cal members face trying to understand and navigate subcontracted services. Yunkyung Kim, CalOptima Chief Operating Officer, was interviewed for the article, which includes a one-paragraph reference to CalOptima's structure.
- On December 29, the OC Breeze ran an online article on the Board's approval of $45 million in provider incentives for CalAIM.
- On December 29, KFI radio aired an interview with Interim CEO Michael Hunn and COO Yunkyung Kim on the CalAIM and vaccination incentives, and services for members experiencing homelessness. (Clip begins at 10:00:10.)
- On December 30, KNX radio aired an interview with Interim CEO Michael Hunn discussing CalOptima's benefits for the vulnerable and how to sign up. (Clip begins at 08:17:02.)
- On January 4, the OC Breeze ran an online article on CalOptima's launch of CalAIM on January, as did the subscription-only Payers & Providers California newsletter.
- On January 17, HealthLeaders and Newsbreak ran an online interview with Interim CEO Michael Hunn and COO Yunkyung Kim discussing CalOptima's work on implementing CalAIM and updating the strategic plan.

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MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

December 20, 2021

A Special Meeting of the CalOptima Board of Directors was held on December 20, 2021 at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021) which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings. Chairman Andrew Do called the meeting to order at 2:00 p.m. and Vice Chair Corwin led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga, M.D.; Scott Schoeffel; Nancy Shivers
(All Board Member attendees participated remotely except Chairman Do, Director Chau and Director Contratto)

Members Absent: Isabel Becerra; Tran Trieu, M.D.

Others Present: Michael Hunn, Interim Chief Executive Officer; Gary Crockett, Chief Counsel; Yunkyung Kim, Chief Operating Officer; Eric Rustad, Executive Director, Finance; Emily Fonda, M.D., Chief Medical Officer; Wael Younan, Chief Information Officer; Sharon Dwiers, Clerk of the Board

Chairman Do announced that Agenda Item 41 has been continued to a future meeting due to a lack of a quorum.

PRESENTATIONS/INTRODUCTIONS

Chairman Do welcomed new Directors Blair Contratto and José Mayorga, M.D. to the CalOptima Board.

The Clerk of the Board administered the ceremonial oath of office for Directors Contratto and Mayorga.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Interim Chief Executive Officer, highlighted several items from his report, including thanking staff for the work that went into preparing for this meeting. Mr. Hunn welcomed CalOptima's newest staff members, Wael Younan, Chief Information Officer, Kelly Giardina, Executive Director, Program Implementation, who is also serving as Interim Executive Director, Clinical Operations, and Veronica Carpenter, Chief of Staff. He also provided an update on the backlog of Utilization Management (UM) authorizations, noting that CalOptima leadership will conduct a root cause analysis to determine what lead to the backlog and ensure that members receive timely consideration of

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authorization requests going forward. Mr. Hunn also provided brief updates on the California Advancing and Innovating Medi-Cal (CalAIM) initiative and the Department of Health Care Services (DHCS) transition of Medi-Cal Pharmacy Services to Medi-Cal Rx, noting that additional information is included in his report and will be shared later in the meeting. In addition, Mr. Hunn highlighted the work being done with regard to the Student Behavioral Health Incentive Program (SBHIP). Chairman Do suggested working with the Health Care Agency in order to get this program started as soon as possible as Dr. Chau and his team have been working with the school districts and can be of assistance.

2. Chief Medical Officer Updates

Emily Fonda, M.D., Chief Medical Officer, provided an update on CalOptima's COVID-19 vaccination efforts. Dr. Fonda reported that, as of December 31, 2021, 67% of CalOptima members aged 16 and over, and 65% of CalOptima members aged 12 and over, have received at least one dose of a COVID-19 vaccine. Dr. Fonda also reported that CalOptima continues to support vaccination clinics in collaboration with the Orange County Health Care Agency and other community partners.

3. CalAIM Update

Yunkyung Kim, Chief Operating Officer, provided an update on CalOptima's CalAIM efforts. Ms. Kim reported that the state has approved all parts CalOptima's model of care (MOC), and noted that as the MOC is revised and refined, staff will update the Board ahead of any revisions being sent to the DHCS for approval. Ms. Kim also noted that the state has extended the deadline for managed care plans to submit their proposed use of incentive payments in CalAIM program year one, and that more details will be provided later in the meeting. Ms. Kim added that, starting January 1st, CalOptima will be providing Enhanced Care Management and Community Support Services to eligible CalOptima members with a small number of providers and that we are looking to add other providers that are able to provide these types of services, with Board approval.

PUBLIC COMMENTS

There was no request for public comment.

CONSENT CALENDAR

4. Minutes

a. Approve Minutes of the November 4, 2021 Regular Meeting of the CalOptima Board of Directors
b. Receive and File Minutes of the September 8, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee and of the September 16, 2021 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee

5. Consider Adopting Resolution No. 21-1220-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

6. Consider Approval of Funding for an Independent Validation Audit as Required to Close Out the CMS Program Audit for the OneCare and OneCare Connect Programs

7. Consider Approval of Modifications to Policy GA.3400: Annual Investments

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8. Consider Approval of Modifications to CalOptima Policy FF.3001: Financial Reporting

9. Consider Approval of Modifications to CalOptima's Pharmacy Management Policies and Procedures

10. Consider Authorization of Unbudgeted Expenditures for PACE and Appropriate Funds in the CalOptima Fiscal Year 2021-22 Operating and Capital Budgets

11. Consider Approval of Extension of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

12. Consider Appointment to the CalOptima Board of Directors Member Advisory Committee

13. Consider Appointment to the CalOptima Board of Directors OneCare Connect Member Advisory Committee

14. Consider Authorization of Expenditures in Support of CalOptima Participation in Community Events

15. Consider Authorizing an Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022

16. Consider Approval of Proposed Changes to CalOptima Quality Improvement Policy GG.1608: Full Scope Site Reviews

17. Consider Approval of the Calendar Years 2022 and 2023 Health Network Medi-Cal Pay for Value Performance Program

18. Consider Approval of the Calendar Year 2022 Health Network OneCare Connect Pay for Value Program Payment Methodology

19. Consider Extending the Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy for Calendar Year 2022

20. Consider Approval of Action Related to the Student Behavioral Health Incentive Program

21. Consider Approval of Actions Related to the Homekey Program Grant Agreement with the Orange County Health Care Agency
Director Chau did not participate in this item due to his role as the Director of the Orange County Health Care Agency. Director Schoeffel did not participate in this item due to potential conflicts of interest.

22. Consider Actions to Extend and Modify the Whole-Person Care Grant Agreements with the Orange County Health Care Agency
Director Chau did not participate in this item due to his role as the Director of the Orange County Health Care Agency. Director Schoeffel did not participate in this item due to potential conflicts of interest.

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23. Consider Ratification of the Contract with Advanced Medical Reviews (AMR) for External Medical Review Services and Authorization of Reallocation of Budgeted but Unspent Dollars

24. Consider Allocation of Additional Intergovernmental Transfer (IGT) 10 Funds to Support the Orange County Coronavirus (COVID-19) Skilled Nursing Facility Prevention Program for Calendar Year (CY) 2021

Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

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

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors approved Consent Calendar as presented. (Motion carried 6-0-0 (except as noted); Director Schoeffel absent on items 21-22; Directors Mayorga and Schoeffel absent on item 24; Directors Becerra and Tran absent)***

CLOSED SESSION

The Board adjourned to Closed Session at 2:48 p.m. pursuant to: Government Code section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS Property: 500 City Parkway West, Orange, CA 92868, Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight Frank Negotiating Parties: Greenlaw Partners, LLC, Under Negotiation: Price and Terms of Payment ~~Agreement~~; Government Code section 54957(b)(1): ASSESSMENT OF KENNADAY LEAVITT, PC.'S JOB PERFORMANCE THROUGH ITS CONTRACT FOR OUTSIDE GENERAL COUNSEL SERVICES. An assessment and review of Kennaday Leavitt's capability, capacity, and quality of its performance of its contract for Outside General Counsel Services.

Rev. 12/20/21

The Board reconvened in open session at 4:13 p.m. The Clerk reestablished a quorum.

ROLL CALL

Members Present: Andrew Do, Chairman; Clayton Corwin, Vice Chair; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga, M.D. (left meeting at 5:00 p.m.); Nancy Shivers
(All Board Members participated remotely except Chairman Do, Director Chau and Director Contratto who attended in person)

Members Absent: Isabel Becerra; Scott Schoeffel (during role call); Tran Trieu, M.D.

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Others Present: Michael Hunn, Interim Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Eric Rustad, Executive Director, Finance; Emily Fonda, M.D., Chief Medical Officer, Wael Younan, Chief Information Officer, Gary Crockett, Chief Counsel; Sharon Dwiers, Clerk of the Board

CS-1. Pursuant to Government Code Section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS Property: 500 City Parkway West, Orange, CA 92868, Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight Frank Negotiating Parties: Greenlaw Partners, LLC, Under Negotiation: Price and Terms of Payment ~~Agreement~~

Rev. 12/20/21

Following closed session, Mr. Hunn reported that the Board of Directors would be considering an amendment to the contract with Newmark Knight Frank to include an amount of up to $50,000 for expenditures for services related to the purchase of 500 City Parkway West, Orange, CA 92868.

CS-2. Pursuant to Government Code Section 54957(b)(1): ASSESSMENT OF KENNADAY LEAVITT, PC.'S JOB PERFORMANCE THROUGH ITS CONTRACT FOR OUTSIDE GENERAL COUNSEL SERVICES. An assessment and review of Kennaday Leavitt's capability, capacity, and quality of its performance of its contract for Outside General Counsel Services

No reportable action taken in closed session on agenda item CS-2.

Chairman Do announced he was splitting the Report Items into several groups. The first group includes Agenda Items 26 through 32, the second group includes Agenda Items 35-37, the third group includes Agenda Items 39, 44, 47, and 49, and the fourth group includes Agenda Items 40 and 55. After which, Chairman Do will pass the gavel to Vice Chair Corwin as he is abstaining on the items in the fifth group based on conflicts of interest based on campaign contributions under the Levine Act. The fifth group includes Agenda Items 33, 34, 38, 41-43, 45, 46, 48, and 50-54.

In the first group, Agenda Items 26 through 32, the Clerk read the items into the record and the Board considered those items in a single motion and vote.

REPORTS/DISCUSSION ITEMS

On motion of Vice Chair Corwin, seconded and carried, the Board of Directors took the following actions:

26. Consider Adoption of Resolution Approving Revised CalOptima 2022 Compliance Plan and Approval of Revised Office of Compliance Policies and Procedures

Action: ***1.) Adopted Resolution No. 21-1220-02 approving the revised CalOptima 2022 Compliance Plan; and 2.) Approved revised Office of Compliance Policies and Procedures (Motion carried 7-0-0 (except as noted) Directors Becerra and Tran absent)***

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27. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Human Resources Policies and Employee Handbook

Action: ***Adopted Resolution Approving Updated CalOptima Policies: 1.) GA.8032: Employee Dress Code and Attachment A; 2.) GA.8036: Education Reimbursement and Attachment A; 3.) GA.8037: Leave of Absence and Attachment A; 4.) GA.8038: Personal Leave of Absence and Attachment A; 5.) GA.8039: Pregnancy Disability Leave of Absence and Attachment A; 6.) GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence and Attachment A; 7.) GA.8041: Workers' Compensation Leave of Absence and Attachments A D; and 8.) Employee Handbook (Motion carried 7-0-0 (except as noted; Directors Becerra and Tran absent)***

28. Consider Appropriating Funds and Authorizing Unbudgeted Expenditures to Cover Staffing Costs Associated with Adding Employees Dedicated to Utilization Management and Grievance and Appeals Resolution Services

Action: ***1.) Authorized the addition of seven (7) unbudgeted positions as follows: a) Three (3) positions for the Utilization Management Department (UM); b) Four (4) positions for the Grievance and Appeals Resolution Services Department (GARS); and 2.) Appropriated funds and authorized unbudgeted expenditures in an amount up to $414,000 from existing reserves to fund salaries and benefits for the additional positions from the date of Board approval through June 30, 2022. (Motion carried 7-0-0 (except as noted); Directors Becerra and Tran absent)***

29. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Policy GA.8044: Telework Program, Authorization of the Expansion of the Telework Program, Transition and Phase-Out of the Temporary Telework Program, and Authorization and Appropriation of Funds for Unbudgeted Expenditures Related to the Expansion of the Telework Program

Action: ***1.) Adopted Resolution No. 21-1220-03 Approving Updated CalOptima Policy GA.8044: Telework Program; 2). Authorized the expansion of the Telework Program, including an increase in full telework positions of up to fifty percent (50%) of the total CalOptima budgeted headcount at any given time and implementation of partial telework positions; 3.) Authorized the gradual transition and phase-out of the Temporary Telework Program beginning February 1, 2022; 4.) Authorized and appropriated funds for unbudgeted expenditures in an amount up to $964,000 from existing reserves for furniture, information services equipment, and other related expenses associated with the Telework Program expansion; and 5.) Authorized the Chief Executive Officer to***

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administer the Telework Program consistent with the Telework Program Policy and Telework Program Guidelines. (Motion carried 7-0-0 (except as noted); Directors Becerra and Tran absent)

30. Consider Authorization of Proposed Budget Reallocation of Fiscal Year 2021-22 Operating Budget Funds and Authorization of Unbudgeted Expenditures and Appropriation of Funds for Information Services Items

Action: ***1.) Authorized the reallocation of $120,000 for The Burgess Group, LLC, to different budget categories within the budget for the same vendor as follows: a.) $50,000 from Medi-Cal: "Other Operating Expenses: Maintenance" to expense category "Medi-Cal: Purchased Services;" and b.) $70,000 from "Medi-Cal: Other Operating Expenses: Maintenance" to expense category "OneCare Connect: Purchased Services"; and 2.) Authorized unbudgeted expenditures and appropriated funds from existing reserves for Information System expenses based on existing contracts with the referenced vendors in amounts up to: a.) $8,000 to expense category "OneCare Connect: Purchased Services" for Infocrossing, A WIPRO Company; and b.) $60,000 to expense category "Medi-Cal: Other Operating Expenses: Purchased Services" for Imagenet, LLC. (Motion carried 7-0-0 (except as noted); Directors Becerra and Tran absent)***

31. Request that the Board of Directors Approve a Six-Month Contract Extension with Medecision to Support the CalOptima Links Portal and Authorize Unbudgeted Expenditures and Appropriate Funds in the CalOptima Fiscal Year 2021-22 Operating Budget to Maintain the CalOptima Link Portal Through Fiscal Year 2021-22 and to Complete the Transition to the CalOptima In-House Provider Portal

Action: ***1.): Authorized an amendment to the contract with Medecision, Inc. to extend the term from December 31, 2021, to June 30, 2022; and 2.) Authorized $795,000 in unbudgeted expenditures and appropriated funds from existing reserves for Information System to fund vendor licensing and maintenance fees through June 30, 2022, data archiving and transfer, and system security enhancements. (Motion carried 7-0-0 (except as noted); Directors Becerra and Tran absent)***

32. Consider Approval of CalAIM System Contract Amendment with Safety Net Connect (SNC) to Support Referral, Authorization, and Billing Processes for Enhanced Care Management (ECM) and Community Supports (aka: ILOS) and Authorization of Unbudgeted Expenditures for SNC Information Services Related Items

Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health.

Action: ***1.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with Safety Net Connect (SNC) to expand the scope of the existing contract to provide additional***

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functionality to support CalAIM initiatives; and 2.) Authorized unbudgeted expenditures and appropriated funds from existing reserves in amounts up to: a. $367,600 to Applications Development – Professional Fees in the Fiscal Year (FY) 2021-2022 Capital Budget for additional professional services; and b. $192,000 to Medi-Cal – Other Operating Expenses in the FY 2021-2022 Operating Budget for maintenance fees through June30, 2022. (Motion carried 6-0-0 (except as noted) Director Mayorga recused; Directors Becerra and Tran absent)

The second group, Agenda Items 35 through 37, were read into the record and the Board considered those agenda items in a single motion and vote.

On motion of Vice Chair Corwin, seconded and carried, the Board of Directors took the following actions:

35. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.
Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

Action: ***1.) Approved Program Year (PY) 1 CalAIM Performance Incentive Payment Methodology for the Medi-Cal line of business for Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C., that defines measures and allocations effective January 1, 2022, through December 31, 2022; 2.) Authorized the allocation and distribution of CalAIM Program Incentive Dollars for PY 1 to CalOptima and delegated health networks in accordance with the recommended methodology and in an aggregate amount for all health networks not to exceed $45 million; and 3.) Authorized funding for and the distribution of incentive payments prior to CalOptima's receipt of CalAIM Program Incentive Dollars from the State of California. (Motion carried 5-0-0 (except as noted above); Director Shivers recused; Directors Schoeffel, Becerra and Tran absent)***

36. Consider Approval of CalOptima Medical Affairs and Claims Administration Policies and Procedures Related to Enhanced Care Management and Community Supports
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***Approved the following new and updated CalOptima Policies: 1.) GG.1353 Enhanced Care Management Service Delivery; 2.) GG.1354 Enhanced Care Management Eligibility and Outreach; 3.) GG.1355 Community Supports; 4.) GG.1356 Enhanced Care Management Administration; and 5.) FF.2001 Claims Processing for Covered Services for which CalOptima is Financially Responsible.***

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(Motion carried 6-0-0 (except as noted); Directors Schoeffel, Becerra and Tran absent)

37. Consider Approving Amendment VII to the Kaiser Foundation Health Plan Inc. Contract for Health Care Services to Include for the Provision of Enhanced Care Management and Community Supports Services, the Transition of Pharmacy Benefits to Medi-Cal Rx and Other Technical Changes

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

Action: ***Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Kaiser Foundation Health Plan, Inc. (Kaiser) Contract for Health Care Services (Contract), effective January1, 2022, as follows: 1.) Included the Enhanced Care Management benefit, as part of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Initiative; 2.) Included the Community Supports services benefit as part of DHCS' CalAIM Initiative; 3.) Revised references to Medi-Cal pharmacy services to support the transition of pharmacy benefits to the DHCS Medi-Cal Rx delivery system, including capitation rate adjustment for exclusion of pharmacy services; 4.) Included language reflecting correction of effective dates and removal of pharmacy benefits from Amendment V, Attachment E-Capitation Rates; and 5.) Aligned the Corrective Action Plan section of the Contract with current CalOptima policy. (Motion carried 6-0-0 (except as noted); Directors Schoeffel, Becerra and Tran absent)***

The third group of Agenda Items included items 39, 44, 47 and 49. These items were read into the record and the Board considered them in a single motion and vote.

On motion of Supervisor Chaffee, seconded and carried, the Board of Directors took the following actions:

39. Consider Approving Amendments to Health Network Medi-Cal Contracts for ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C. for the Provision of Enhanced Care Management, Transition of Pharmacy Benefits to Medi-Cal Rx and Alignment of the Corrective Action Plan Section of the Contracts with Current Policy

Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

Action: ***Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the health network Medi-Cal contracts for health care services for ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert), as follows: 1.) Included the Enhanced Care Management benefit, as part of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal initiative; 2.) Revised references to Medi-Cal pharmacy services to support the***

transition of pharmacy benefits to the DHCS Medi-Cal Rx delivery system; and 3.) Aligned the Corrective Action Plan section of the contracts with current policy. (Motion carried 5-0-0 (except as noted); Director Shivers recused; Directors Schoeffel, Becerra and Tran absent)

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

Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

Action: ***Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare health network contracts for ARTA Western California Inc. (ARTA), Monarch Healthcare, A Medical Group Inc. (Monarch), and Talbert Medical Group P.C. (Talbert) as follows: 1.) Extended the health network contracts through December 31, 2022; 2.) Extended allocation of non-Part D CMS Capitation through the end of calendar year 2022; and 3.) Aligned the Corrective Action Plan section of the contracts with current policy. (Motion carried 5-0-0 (except as noted); Director Shivers recused; Directors Schoeffel, Becerra and Tran absent)***

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

Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

Action: ***Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Connect health network contracts for ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert), as follows: 1.) Exercised the final one-year extension option of the health network contracts agreements through December 31, 2022; and 2.) Aligned the Corrective Action Plan section of the contract with current policy. (Motion carried 5-0-0 (except as noted); Director Shivers recused; Directors Schoeffel, Becerra and Tran absent)***

49. Consider Authorizing Extension of a Temporary, Short-Term, Supplemental Capitation Rate Increase for the ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C. Medi-Cal Health Networks for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members

Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

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Action: ***Recommended that the Board of Directors authorize the following actions for the ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert) Medi-Cal Health Networks: 1.) Extending capitation rate increases for the ARTA, Monarch, and Talbert Medi-Cal health networks on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA) by 7.5% from Fiscal Year (FY) 2021-22 original budgeted base rates for the period of January 1, 2022, through June 30, 2022; 2.) Use of unbudgeted expenditures in an aggregate amount for all health network up to $16.2 million from existing reserves to provide funding for Health Network capitation rate adjustments; and 3.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the for ARTA, Monarch, and Talbert Medi-Cal health network contracts to implement the health network capitation rate adjustments. (Motion carried 5-0-0 (except as noted); Director Shivers recused; Directors Schoeffel, Becerra and Tran absent)***

The fourth group of Agenda Items included items 40 and 55. These were read into the record and the Board considered them in a single motion and vote.

On motion of Supervisor Chaffee, seconded and carried, the Board of Directors took the following actions:

40. Consider Authorizing an Amendment to CalOptima's Coordination and Provision of Public Health Care Services Contract with the County of Orange to Provide Targeted Engagement and Coordination Services, and Enhanced Care Management (ECM) for Members with Serious Mental Illness (SMI) and Substance Use Disorders (SUD) within the CalAIM Program
Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Chau did not participate in this item due to his role as the Director of the Orange County Health Care Agency.

Action: ***1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's current Public Healthcare Services contract with the County of Orange to reimburse the County for services provided to CalOptima members in the California Advancing and Innovating Medi-Cal (CalAIM) program from January 1, 2022, through December 31, 2022, including Targeted Engagement and Coordination Services during the transition from the Whole Person Care (WPC) Program; and 2.) Authorized unbudgeted expenditures in an amount up to $2 million from existing reserves for expenses associated with the ECM risk corridor and reconciliation process. (Motion carried 6-0-0 (except as noted); Directors Schoeffel, Becerra and Tran absent)***

55. Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***1.) Extended the Clinical Field Team Pilot Program (CFTPP) and Homeless Health Initiative (HHI) Federally Qualified Health Center (FQHC) Expansion***

Pilot through December 31, 2022; and 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contracts covering those programs to reflect that extension. (Motion carried 6-0-0 (except as noted); Directors Schoeffel, Becerra and Tran absent)

As noted, for the fifth group, Chairman Do abstained due to conflicts of interest based on campaign contributions under the Levine Act and turned the gavel over to Vice Chairman Corwin. The fifth group included Agenda Items 33,34, 38, 41-43; 45, 46, 48 and 50-54.

Vice Chair Corwin further split the fifth group of the agenda items into three smaller subgroups. The first subgroup included Agenda Items 33, 34, and 38, which the Clerk read into the record and the Board considered them in a single motion and vote.

On motion of Supervisor Chaffee, seconded and carried, the Board of Directors took the following actions:

33. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for All Health Networks, Except AltaMed Health Services Corporation, Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***1.) Approved Program Year (PY) 1 CalAIM Performance Incentive Payment Methodology for the Medi-Cal line of business for all health networks, except AltaMed Health Services Corporation, Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C. that defines measures and allocations effective January 1, 2022, through December 31, 2022; 2.) Authorized the allocation and distribution of CalAIM Program Incentive Dollars or PY 1 to CalOptima and delegated health networks in accordance with the recommended methodology in an aggregate amount for all health networks not to exceed $45.0 million; and 3.) Authorized funding for and the distribution of incentive payments prior to CalOptima's receipt of CalAIM Program Incentive Dollars from the State of California. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)***

34. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for AltaMed Health Services Corporation
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***1.) Approved Program Year (PY) 1 CalAIM Performance Incentive Payment Methodology for the Medi-Cal line of business for AltaMed Health Services***

Corporation that defines measures and allocations effective January 1, 2022, through December 31, 2022; 2.) Authorized the allocation and distribution of CalAIM Program Incentive Dollars for PY 1 to CalOptima and delegated health networks in accordance with the recommended methodology in an aggregate amount for all health networks not to exceed $45 million; and 3.) Authorized funding for and the distribution of incentive payments prior to CalOptima's receipt of CalAIM Program Incentive Dollars from the State of California. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)

38. Consider Approving Amendments to all Health Network Medi-Cal Contracts Other than Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C, for Provision of Enhanced Care Management, Transition of Pharmacy Benefits to Medi-Cal Rx and Alignment of the Corrective Action Plan Section of the Contracts with Current Policy

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend all health network Medi-Cal contracts other than Kaiser Foundation Health Plan Inc., ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert), for health care services, as follows: 1.) Included the Enhanced Care Management benefit, as part of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal initiative; 2.) Revised references to Medi-Cal pharmacy services to support the transition of pharmacy benefits to the DHCS Medi-Cal Rx delivery system; and 3.) Aligned the Corrective Action Plan section of the contracts with current policy. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)***

As Chairman Do noted at the top of the meeting, Agenda Item 41 was continued.

41. Consider Ratification of Past Use of and Authorization for Continued Use of a Temporary Utilization Management Protocol for Referrals to University of California, Irvine Specialist Physicians

This item was continued to a future meeting due to a lack of a quorum.

The second subgroup of Agenda Items under group five, included agenda items 42, 43, 45, 46, and 48, which the Clerk read into the record and the Board considered them in a single motion and vote.

On motion of Supervisor Chaffee, seconded and carried, the Board of Directors took the following actions:

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

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend all OneCare health network contracts except AltaMed Health Services Corporation (AltaMed), ARTA Western California Inc. (ARTA), Monarch Healthcare A Medical Group Inc. (Monarch), and Talbert Medical Group P.C. (Talbert) as follows: 1.) Extended the health network contracts through December 31, 2022; 2.) Extended allocation of non-Part D CMS Capitation through the end of calendar year 2022; and 3.) Aligned the Corrective Action Plan section of the contracts with current policy. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)***

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

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the AltaMed Health Services Corporation (AltaMed) OneCare health network contract as follows: 1.) Extended the health network contracts through December 31, 2022; 2.) Extended allocation of non-Part D CMS Capitation through the end of calendar year 2022; and 3.) Aligned the Corrective Action Plan section of the contracts with current policy. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)***

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

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to***

amend the OneCare Connect health network contracts for all health networks except AltaMed Health Services Corporation (AltaMed), ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert), as follows: 1.) Exercised the final one-year extension option of the health network contracts agreements through December 31, 2022; and 2.) Aligned the Corrective Action Plan section of the contract with current policy. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)

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

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the OneCare Connect health network contract for AltaMed Health Services Corporation (AltaMed) as follows: 1.) Exercised the final one-year extension option of the health network contracts agreements through December 31, 2022; and 2.) Aligned the Corrective Action Plan section of the contract with current policy. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)***

48. Consider Authorizing Extension of a Temporary, Short-Term, Supplemental Capitation Rate Increase for all Contracted Medi-Cal Health Networks Except ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C. for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***Recommended authorizing the following actions for all Medi-Cal health networks except ARTA Western California Inc.(ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert): 1.) Extending capitation rate increases for all contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organization (HMO) Medi-Cal health networks except ARTA, Monarch, and Talbert on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA) by 7.5% from Fiscal Year (FY) 2021-22 original budgeted base rates for the period of January 1, 2022, through June 30, 2022; 2.) Use of unbudgeted expenditures in an aggregate amount for all health networks up to $16.2 million from existing reserves to provide funding for Health Network capitation rate adjustments; and 3.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend all Medi-Cal PHC, SRG, and HMO Health Network contracts except ARTA, Monarch, and Talbert, to implement***

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the health network capitation rate adjustments. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)

The third subgroup of Agenda Items in group five included items 50 through 54. While the Board took action on Item 53, Agenda Items 50, 51, 52, and 54 were continued to a future meeting due to a lack of a quorum.

50. Consider Authorizing Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members
This item was continued to a future meeting due to a lack of a quorum.

51. Consider Authorizing Extension of a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members
This item was continued to a future meeting due to a lack of a quorum.

52. Consider Authorizing Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Hospitals, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct- Medi-Cal Members
This item was continued to a future meeting due to a lack of a quorum.

53. Consider Approving Amendments to Skilled Nursing Facility (SNF) Ancillary Contracts to Increase Rates for Medi-Cal, OneCare, OneCare Connect, and Program of All-Inclusive Care for the Elderly Services
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the current Medi-Cal, OneCare, OneCare Connect, and Program of the All-Inclusive Care for the Elderly (PACE) Ancillary Fee-for-Service (FFS) Skilled Nursing Facilities (SNF) contracts to reflect increases to reimbursement rates for all four programs effective January 1, 2022; and 2.) Authorized unbudgeted expenditures in an amount up to $925,000 from existing reserves to fund the increase to reimbursement rates for OneCare, OneCare Connect and PACE Ancillary FFS SNF contracts through June 30, 2022. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Schoeffel, Becerra, and Tran absent)***

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54. Consider Authorizing Amendments to the CalOptima Community Network Contracts to Add OneCare as a Covered CalOptima Program
This item was continued to a future meeting due to a lack of a quorum.

ADVISORY COMMITTEE UPDATES

56. OneCare Connect Member Advisory Committee Update
Patty Mouton, OneCare Connect Member Advisory Committee (OCC MAC) Chair, was unable to attend the meeting today. Her report on the OCC MAC recent and upcoming activities is in the Board materials.

57. Provider Advisory Committee Update
58. Member Advisory Committee Update
Christine Tolbert, Member Advisory Committee (MAC) Chair, provided updates on recent and upcoming activities of both the MAC and the Provider Advisory Committee (PAC).

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
Supervisor Chaffee noted that the County is getting ready for the Point in Time Count and asked for volunteers to help with the count.

Board members again welcomed Directors Contratto and Mayorga and wished everyone a Merry Christmas and Happy Holiday Season.

ADJOURNMENT
Hearing no further business, Chairman Do adjourned the meeting at 5:09 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: February 3, 20222

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

3. Adopt Board Resolution No. 22-0203-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Contact

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

Recommended Action

Adopt Board Resolution No. 22-0203-01, authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e).

Background

Under the Ralph M. Brown Act, California Government Code Section 54950 *et seq.*, (Brown Act) meetings of California local public bodies must be open and public. Prior to the COVID-19 pandemic, the Brown Act has generally allowed a local agency to use teleconferencing for public meetings, subject to specific agenda, posting, physical access, and quorum requirements. On March 4, 2020, pursuant to Government Code section 8625, Governor Gavin Newsom declared a state of emergency related to the COVID-19 pandemic. On November 10, 2021, Governor Newsom issued Executive Order N-21-21, extending the state of emergency through March 31, 2022, and the declaration of emergency continues in effect and has not been lifted or rescinded.

On March 17, 2020, Governor Newsom signed Executive Order N-29-20, suspending certain provisions of the Brown Act, including, in part, suspending the requirement for in-person legislative meetings and suspending the requirement that each teleconference location be accessible to the public. The Governor's Executive Order expired on September 30, 2021.

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

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

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

Discussion

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

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

Given the continued active declaration of emergency arising from the COVID-19 pandemic and the Governor's extension of the declaration of a state of emergency through March 31, 2022, there is an ongoing need for holding teleconference meetings for the CalOptima Board of Directors and its advisory committees. In addition, the County of Orange Health Officer issued "Orders and Strong Recommendations," updated as of January 14, 2022, to strongly recommend preventative measures such as avoiding gathering and practicing social distancing. For CalOptima to continue the teleconference meetings, the required finding are set forth in the attached Resolution No. 22-0203-01.

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Resolution No. 22-0203-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with Government Code section 54953, subdivision (e)
2. March 4, 2020, Proclamation of a State of Emergency
3. November 10, 2021, Extension of the State of Emergency
4. January 14, 2022, Orange County Health Officer's Orders and Strong Recommendations
5. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0203-01

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

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

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

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

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

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

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

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

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

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

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

WHEREAS, on November 10, 2021, the Governor extended the state of emergency through March 31, 2022; and

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

WHEREAS, on January 14, 2022, the County of Orange Health Officer issued a revised "Orders and Strong Recommendations," which includes strong recommendations for preventative measures, such as avoiding gathering and practicing social distancing; and

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

I. That the CalOptima Board of Directors has duly considered the active status of the current state of emergency through March 31, 2022, along with the County of Orange Health Officer's strong recommendation to continue implementing COVID-19 preventative measures, such as social distancing, and has found that the state of emergency continues to directly impact the ability of the CalOptima Board of Directors and its advisory committees to meet safely in person,

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

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

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 3rd day of February, 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

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

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

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

PROCLAMATION OF A STATE OF EMERGENCY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IT IS HEREBY ORDERED THAT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-21-21

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS in response to the ongoing COVID-19 pandemic and increased spread of the Delta variant, on August 16, 2021, I issued Executive Order N-12-21 to ensure the State's health care facilities continue to have the staffing and resources needed to prevent potential strain on the State's health care delivery system; and

WHEREAS on October 4, 2021, I issued Executive Order N-17-21 to extend flexibilities allowing the State to increase health care capacity to support ongoing testing and vaccination efforts and minimize the threat of COVID-19 to Californians; and

WHEREAS California has stopped recording week-over-week declines in COVID-19 cases and hospitalizations, which demonstrates a plateau and the potential beginning of a new surge in COVID-19 cases; and

WHEREAS as flu season approaches, it is critical that California's health care facilities, already short-staffed and backlogged from the Delta variant and with high-levels of non-COVID-19 admissions, have the flexibilities that they need for additional capacity and to prevent staffing shortages; and

WHEREAS California continues to prioritize efforts to vaccinate all eligible individuals against COVID-19, including ensuring access to boosters and vaccines for newly eligible populations; and

WHEREAS supporting robust COVID-19 testing capacity remains critical in the efforts to protect public health and mitigate the impacts of the pandemic; and

WHEREAS continued flexibility in non-hospital settings remains necessary to support these ongoing testing and vaccination efforts and to minimize the threat of COVID-19 to vulnerable Californians; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes, regulations, and certain

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IT IS HEREBY ORDERED THAT:

1. The timeframes set forth in Executive Order N-12-21, paragraphs 1 through 6, are hereby extended through March 31, 2022.

2. The timeframe set forth in Executive Order N-17-21, Paragraph 1, is hereby extended through March 31, 2022.

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

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 10th day of November 2021.

GAVIN NEWSOM
Governor of California

ATTEST:

SHIRLEY WEBER, PH.D.
Secretary of State

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CLAYTON CHAU, MD PhD
DIRECTOR/COUNTY HEALTH OFFICER

REGINA CHINSIO-KWONG, DO
DEPUTY COUNTY HEALTH OFFICER

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

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COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS

(Revised January 14, 2022)

In light of the recent quarantine and isolation guidelines announced/issued by Centers for Disease Control and Preventions (CDC) and California Department of Public Health (CDPH), the following Orders and Strong Recommendations shall revise and replace the prior Orders and Strong Recommendations of the County Health Officer that were issued on January 4, 2022. The Orders and Strong Recommendations issued on January 4, 2022, are no longer in effect as of January 14, 2022.

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

ORDERS

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

I. Self-Isolation and Self-Quarantine Orders

NOTE: Refer to the Definition Section below for the meaning of terms used in this isolation and quarantine orders, e.g., exposure to COVID-19, symptoms, etc.

A. Self-isolation of Persons with COVID-19

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

1. Persons who test positive for COVID-19. Persons who test positive for COVID-19 shall immediately isolate themselves in their home or another suitable place for at least 5 days. They may discontinue self-isolation after day 5 from the date they test positive IF:

    - COVID-19 symptoms are not present and a diagnostic specimen collected on day 5 or later tests negative.

        - An antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, however, if it is recommended that persons use an antigen test for ending isolation. Use of Over-the-Counter tests are also acceptable to end isolation.

    - If unable to test, choose not to test, or test positive by repeat testing, and symptoms are not present or not resolving, isolation shall continue through day 10 and may end after 10 days regardless of whether symptoms are present or resolving.

    - They should continue to wear a well-fitting mask at all times around other people through at least day 10.

2. Persons who have symptoms. Persons who have COVID-19 symptomatic shall immediately isolate themselves in their home or another suitable place for 5 days from the date of their symptom onset. They may end isolation IF:

    - A diagnostic specimen collected as early as the onset of their symptoms or later tests negative.

        - An antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, however, if it is recommended that persons use an antigen test for ending isolation. Use of Over-the-Counter tests are also acceptable to end isolation.

- If fever is present, isolation shall continue until fever resolves without the use of fever-reducing medications.
- If symptoms other than fever are not resolving, isolation shall continue (i) until symptoms are resolving or (ii) for 10 days regardless of whether symptoms are resolving or not.
- If unable to test, choose not to test, or test positive by repeat testing, and symptoms are not present or not resolving, isolation shall continue through day 10 and may end after 10 days regardless of whether symptoms are present or resolving.
- They should continue to wear a well-fitting mask at all times around other people through at least day 10.

3. Additional Considerations for Self-Isolation.

   - A person who is self-isolated may not leave his or her place of isolation except to receive necessary medical care.
   - If a more specific and individualized isolation order is issued by the County Health Officer for any county resident, the resident shall follow the specific order instead of the order herein.
   - People who are severely ill with COVID-19 might need to stay in self-isolation longer than 5 days and up to 20 days after symptoms first appeared. People with weakened immune systems should talk to their healthcare provider for more information.

B. Exemption from Isolation

- Health care providers who (i) work at general acute care hospitals, acute psychiatric hospitals, and skilled nursing facilities; (ii) have tested positive for COVID-19; and (iii) do not have any symptoms are not required to isolate per this Order. This exemption is effective through February 1, 2022. They shall wear an N95 respirator for source control. Facilities implementing this exemption (i) must have made every attempt to bring in additional registry or contract staff and must have considered

modifications to non-essential procedures; and (ii) should preferably assign them to work with COVID-19 positive patients.

C. Self-Quarantine of Persons Exposed to COVID-19

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

1. Not-up-to-date personas. Persons who (i) do not have symptoms; (ii) are not-up-to-date with COVID-19 vaccination; and (iii) know they have been exposed to COVID-19 shall quarantine for at least 5 days after their most recent exposure to COVID-19. Self-quarantine may end after day 5 IF:

   - Person has not developed any symptoms and a diagnostic specimen collected on day 5 or later tests negative.
     - Use of Over-the-Counter tests are acceptable to end quarantine.
   - If the person is unable to test or chooses not to test, s/he shall quarantine for 10 days after most recent exposure to COVID-19.
   - Additionally, the person should continue to wear a well-fitting mask around other people through at least day 10 after most recent exposure to COVID-19.

D. Exemptions from Quarantine

1. Asymptomatic up-to-date persons. Persons who (i) are up-to-date with COVID-19 vaccinations prior to their exposure to COVID-19; and (ii) have not developed any symptoms since their exposure to COVID-19 are not required to quarantine.

   - They should test on day 5 from date of exposure to COVID-19. If they test positive, they shall immediately self-isolate, as ordered above, and contact their healthcare provider with any questions regarding their care.
   - They should continue to wear a well-fitting mask at all times around other people through at least day 10 after their exposure to COVID-19.

2. Asymptomatic persons previously infected. Persons who (i) are exposed to COVIV-19; (ii) test positive for COVID-19 before their new, recent exposure to COVID-19; and (iii) it has been less than 3 months since they started having

symptoms from that previous infection (or since their first positive COVID-19 test if asymptomatic), are not required to quarantine per this Order, as long as they have not had any new symptoms since their recent exposure to COVID-19.

3. Exposed Asymptomatic Emergency Responders and Health Care Workers. During critical staffing shortages, exposed emergency responders and health care workers who do not have any symptoms are not required to quarantine. They should wear a well-fitting mask at all times when around others for at least 10 days after their most recent exposure to COVID-19 and monitor for symptoms of COVID-19.

4. Non-health care provider and non-emergency workers. All non-health care provider and non-emergency responder workers (i) who are fully vaccinated and eligible for a booster shot but have not yet obtained their booster shot; and (ii) who do not have symptoms are not required to quarantine per this Order if:

   - A diagnostic specimen collected on day 5 or later tests negative (use of Over-the-Counter tests are acceptable); and
   - The worker wears a well-fitting mask around others for 10 days from date of last exposure to COVID-19; and
   - The worker does not develop any symptoms.

5. Quarantine of Students in both Private and Public Transitional Kindergarten through Grade 12. Schools/school districts may choose from between the following two models for students who are exposed to COVID-19:

   Option 1. Individual Management – Students in both private and public transitional kindergarten through grade 12 shall follow the isolation and self-quarantine orders above with the following Modified Quarantine exemption:

   Modified Quarantine. If a not-up-to-date student is exposed to COVID-19 and both were wearing mask then the exposed student may continue to attend school for in-person instruction during the duration of his or her quarantine period if the following conditions are met:

   - The exposed student does not develop any symptoms; AND

- The exposed student continues to appropriately wear well-fitting mask; AND
- The exposed student undergoes testing for COVID-19 at least twice during the 5 days quarantine period (use of Over-the-Counter tests are acceptable); AND
- The exposed student refrains from participation in all extracurricular activities at school, including sports, and activities within the community setting for the duration of his or her quarantine period. The exposed student may participate in all required instructional components of the school day, except activities where a mask cannot be worn, such as while playing certain musical instruments. The exposed student may also eat meals on campus.
- If the exposed student is unable to test or chooses not to test, s/he shall quarantine for 10 days after most recent exposure to COVID-19.

Option 2. Group Tracing Approach – For this option, schools will notify groups of students. Groups of students mean those students who spent more than 15 minutes (over a 24-hour period) in the same indoor airspace (e.g., classroom) with someone who has COVID-19, regardless of their vaccination status or previous COVID-19 disease. Notification would be to groups of exposed students (e.g., classmates, teammates, cohorts) rather than the individual students identified in Option 1 (Individual Management), above. The notification will provide the following information:

- Exposure to COVID-19;
- Last known date of exposure to COVID-19;
- The option to continue to attend school so long as they are free of any symptoms (those who develop symptoms shall isolate per the isolation order, above);

- Recommendation to undergo testing 3 to 5 days after most recent exposure to COVID-19;
- Shall wear a well-fitting mask;
- If unable to wear a mask due to a documented exemption the student must quarantine at home until the student has obtained a negative result for the test administered on day 3 to 5 after most recent exposure to COVID-19.
- Students so notified who participate in activities where it is not practicable to participate with a mask on will refrain from that activity until negative results is obtained from the test administered on day 3 to -5 after most recent last exposure to COVID-19. If they are participating in routine testing program, at least once per week they may continue with all activities, so long as they remain asymptomatic and test negative.

In the event of wide-scale and or repeated exposures, broader (grade-wide or campus-wide) once weekly testing for COVID-19 may be chosen in lieu of group notification until such time as exposure events become less frequent.

E. Definitions

The following definitions shall govern the meaning of terms in the isolation and quarantine orders, above.

1. *Symptom(s)*. Whenever the term "symptom" is used, it shall mean COVID-19 symptom. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19:
    - Fever or chills
    - Cough
    - Shortness of breath or difficulty breathing
    - Fatigue

- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

The list above does not include all possible symptoms.

2. *Up-to-date with COVID-19 vaccination*. Persons 12 years and older are considered up-to-date with their COVID-19 vaccination if they have completed a primary series of COVID-19 vaccine and have either received a booster shot or are not yet recommended to receive a booster dose according to current CDC guidance. Those less than 12 years of age are considered up-to-date with their COVID-19 Vaccinations if they have completed their primary series according to CDC guidance:

   CDC COVID-19 Primary Vaccine Series Guidance

   CDC COVID-19 Vaccine Booster Shot Guidance

3. *Not-up-to-date with COVID-19 vaccination*. All persons who do not meet the criteria under up-to-date with COVID-19 vaccination, as defined above, are considered not-up-to-date with their COVID-19 vaccination.

4. *Exposed to COVID-19 or exposure to COVID-19*. These terms mean to be within 6 feet of someone who has COVID-19 for a cumulative total of 15 minutes or more over a 24-hour period.

5. *Emergency responder*. This term includes military or national guard, law enforcement officers, correctional institution personnel, fire fighters, emergency medical services personnel, physicians, nurses, public health personnel, emergency medical technicians, paramedics, emergency

management personnel, 911 operators, child welfare workers and service providers, public works personnel, and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency, as well as individuals who work for such facilities employing these individuals and whose work is necessary to maintain the operation of the facility.

6. *Health care provider*. This term includes physicians; psychiatrists; nurses; nurse practitioners; nurse assistants; medical technicians; any other person who is employed to provide diagnostic services, preventive services, treatment services or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care; and employees who directly assist or are supervised by a direct provider of diagnostic, preventive, treatment, or other patient care services; and employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition. A person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals, building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility.

II. Face-Covering Order:

- **Wear a Cloth Face-Covering**. To help prevent the spread of droplets containing COVID-19, all County residents and visitors shall wear face coverings in accordance with and as required by the Guidance for the Use of Face Coverings issued by CDPH, effective December 15, 2021. The Guidance is attached herein as Attachment "**A**" and can be found at:

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

The Guidance orders, as follows:

Masking Requirements.

Masks are required for all individuals in all indoor public settings, regardless of vaccination status from December 15, 2021, through February 15, 2022. Full guidance can be found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx.

In workplaces, employers are subject to the Cal/OSHA COVID-19 Emergency Temporary Standards (ETS) or in some workplaces the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard and should consult those regulations for additional applicable requirements.

See State Health Officer Order, issued on July 26, 2021 (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx), for a full list of high-risk congregate and other healthcare settings where surgical masks are required for unvaccinated workers, and recommendations for respirator use for unvaccinated workers in healthcare and long-term care facilities in situations or settings not covered by Cal OSHA ETS or ATD.

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

Exemptions to masks requirements.

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

- Persons younger than two years old. Very young children must not wear a mask because of the risk of suffocation.
- Persons with a medical condition, mental health condition, or disability that prevents wearing a mask. This includes persons with a medical condition

for whom wearing a mask could obstruct breathing or who are unconscious, incapacitated, or otherwise unable to remove a mask without assistance.

- Persons who are hearing impaired, or communicating with a person who is hearing impaired, where the ability to see the mouth is essential for communication.
- Persons for whom wearing a mask would create a risk to the person related to their work, as determined by local, state, or federal regulators or workplace safety guidelines.

The County Health Officer strongly recommends that all mask wearers consistently and correctly wear a mask that offers good filtration to get the best protection. To improve efficacy, the mask should fit to minimize gaps between the face and mask. The mask should also fully cover the nose and mouth. If wearing a fabric face covering, three layers should be worn to offer better filtration.

The County Health Officer also strongly recommends wearing a face shield for members of the public who cannot wear a face covering due to a medical condition or other exemption (except for children younger than 2 years old), although they may not work as well as face coverings in their ability to prevent the spread of COVID-19 to others. A cloth “drape” should be attached to the bottom edge of the face shield and tucked into the shirt to minimize gaps between the face and face shield.

III. <u>Vaccination and Testing for COVID-19 Orders</u>:

1. **<u>COVID-19 Vaccination for Workers and Service Providers of Certain Facilities</u>**.
To help prevent transmission of COVID-19, all workers who provide services or work in facilities described below shall comply with the COVID-19 vaccination and booster dose requirements as set forth in the December 22, 2021, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**B**" and can be found at the following link:

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

Facilities covered by this order include:

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

The word, "worker," as used in this Order shall have the same meaning as defined in the State Health Officer's Order, dated December 22, 2021. *See* https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

2. **Requirements for COVID-19 Vaccination Status Verification, COVID-19 Testing, and Masking for Certain Facilities**.

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

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

Facilities covered by this order include:

Acute Health Care and Long-Term Care Settings:

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

High-Risk Congregate Settings:

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

Other Health Care Settings:

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

- Dental Offices
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

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

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

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

4. **Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement**.

   To prevent the further spread of COVID-19 in local correctional facilities and detention centers, all individuals identified in the State Health Officer Order, effective December 22, 2021, shall comply with the State Health Officer's Order with regards to obtaining COVID-19 vaccination and booster doses. A copy of the State Health Officer Order is attached herein as Attachment "**E**" and can be found at the following link:

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

5. **Adult Care Facilities and Direct Care Worker Vaccination Requirements.**

To help prevent transmission of COVID-19, all individuals specified below shall comply with the COVID-19 vaccination and booster does requirements as set forth in the December 22, 2021, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**F**" and can be found at the following link:

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

Individuals covered by this order include:

- All workers who provide services or work in Adult and Senior Care Facilities licensed by the California Department of Social Services;
- All in-home direct care services workers, including registered home care aides and certified home health aides, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services;
- All waiver personal care services (WPCS) providers, as defined by the California Department of Health Care Services, and in-home supportive services (IHSS) providers, as defined by the California Department of Social Services, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services;
- All hospice workers who are providing services in the home or in a licensed facility; and
- All regional center employees, as well as service provider workers, who provide services to a consumer through the network of Regional Centers

serving individuals with developmental and intellectual disabilities, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services.

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

Requirements for Visiting Acute Health Care and Long-Term Care Settings.

To help prevent transmission of COVID-19, all acute health care and long-term care settings shall comply with the indoor visitation requirements set forth in the State Health Officer, effective January 7, 2022 through February 7, 2022. A copy of the State Health Officer Order is attached herein as Attachment "**G**" and can be found at the following link:

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

V. Seasonal Flu Vaccination Order:

Seasonal Flu Vaccination for Certain County Residents.

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

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

facilities employing these individuals and whose work is necessary to maintain the operation of the facility.

- *Health care provider* shall mean physicians; psychiatrists; nurses; nurse practitioners; nurse assistants; medical technicians; any other person who is employed to provide diagnostic services, preventive services, treatment services or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care; and employees who directly assist or are supervised by a direct provider of diagnostic, preventive, treatment, or other patient care services; and employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition. A person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals, building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility.

STRONG RECOMMENDATIONS

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

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

2. **COVID-19 Vaccination for County Residents**. All Orange County residents should receive COVID-19 vaccination in accordance with the Federal Food and Drug

Administration (FDA) and CDC guidance unless a medical contraindication applies. Minors, who are eligible to receive COVID-19 vaccination in accordance with the applicable CDC guidelines, should be vaccinated in the presence of their parent or legal guardian.

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

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

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

GENERAL PROVISIONS

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

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

REASONS FOR THE ORDERS AND STRONG RECOMMENDATIONS

1. On February 26, 2020, the County of Orange Health Officer declared a Local Health Emergency based on an imminent and proximate threat to public health from the introduction of COVID-19 in Orange County.

2. On February 26, 2020, the Chairwoman of the Board of Supervisors, acting as the Chair of Emergency Management Council, proclaimed a Local Emergency in that the imminent and proximate threat to public health from the introduction of COVID-19 created conditions of extreme peril to the safety of persons and property within the territorial limits of Orange County.

3. On March 2, 2020, the Orange County Board of Supervisors adopted Resolutions No. 20-011 and No. 20-012 ratifying the Local Health Emergency and Local Emergency, referenced above.

4. On March 4, 2020, the Governor of the State of California declared a State of Emergency to exist in California as a result of the threat of COVID-19.

5. As of January 14, 2022, the County has reported a total of 430,675 recorded confirmed COVID-19 cases and 5,921 of COVID-19 related deaths.

6. Safe and effective authorized COVID-19 vaccines are recommended by the CDC. According to CDC, anyone infected with COVID-19 can spread it, even if they do NOT have symptoms. The novel coronavirus is spread in 3 ways:1) Breathing in air when close to an infected person who is exhaling small droplets and particles that contain the virus. 2) Having these small droplets and particles that contain virus land on the eyes, nose, or mouth, especially through splashes and sprays like a cough or sneeze. 3) Touching eyes, nose, or mouth with hands that have the virus on them. See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.

7. CDC requires face coverings on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and in U.S. transportation

hubs such as airports and stations. See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html.

8. The CDPH issued a revised Guidance for the Use of Face Coverings, effective December 15, 2021, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx

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

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

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

12. The California Health and Safety Code section 120175 requires the County of Orange Health Officer knowing or having reason to believe that any case of a communicable disease exists or has recently existed within the County to take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases.

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

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

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

IT IS SO ORDERED:

Date: January 12, 2022

Clayton Chau MD, PhD
County Health Officer
County of Orange



GOVERNMENT CODE - GOV

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Any of the following circumstances exist:

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

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

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

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

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

4. Authorization to Enter into Negotiations with the County of Orange to Modify and Extend the Current License Agreement for Use of Space at the County Community Service Center Annex

Contacts

Michael Hunn, Interim Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to negotiate and execute a modification and extension of the License Agreement with the County of Orange for up to an additional four years through June 30, 2026, which allows use of approximately 362 square feet of space at the County Community Service Center Annex (CCSC Annex), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683.

Background

Since 2008, CalOptima has utilized space at the main CCSC office to offer monthly education seminars that aim to increase members' knowledge about CalOptima, Medi-Cal programs, and support services. The County subsequently opened a satellite office (CCSC Annex) in October 2016 where CalOptima established a CalOptima satellite office. One dedicated CalOptima staff is located there and CalOptima utilizes shared space through a paid License Agreement with the County that has a term that runs from August 5, 2016, through June 30, 2022. The current License Agreement fee is $1,705.72 per month, approximately 24% of the County's monthly rent under the lease, which is justified through the amount of space CalOptima occupies and shared common spaces at the CCSC Annex.

Since October 2016, CalOptima staff has provided on-site education about CalOptima's programs and services, customer service support, and bi-monthly educational seminars at the CCSC Annex. In January 2017, CalOptima started offering New Member Orientation for our Vietnamese-speaking members there, and starting in late May 2017, a full-time, bi-lingual Customer Service Representative was designated to the satellite office to serve CalOptima members/potential members. To increase CalOptima's visibility in the community, CalOptima collaborated with community partners to host additional health education seminars and mobile mammogram events in 2018 and 2019 at the CCSC Annex.

In addition to CalOptima's services, the CCSC offers a variety of health and human services, including application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from the Orange County Health Care Agency (a mental health specialist and public health nurse), Orange County Housing Authority, the Family Caregiver Resource Center, the Council on Aging and the Office

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on Aging are on-site to assist members comprehensively with their needs.

In 2019, the total number of visitors assisted by CalOptima staff ranged from 38 to 73 individuals per month. In March 2020, the CCSC Annex closed due to COVID-19, with CalOptima's Customer Service Representative returning to the CCSC Annex in August 2021.

Discussion

The License Agreement, like the County's current lease, is due to expire on June 30, 2022. While the County's current Lease Agreement includes an option to extend the term beyond June 30, 2022, for an additional four (4) year term, the CalOptima License Agreement does not. If extended, the proposed termination date is June 30, 2026. The County has until the end of February to inform the landlord of its intent to exercise its option to extend; once exercised, the landlord and the County may begin negotiations. Due to a historically lengthy process between the landlord and County, CalOptima staff is seeking authority to enter into negotiations now to stay abreast of the latest negotiation efforts.

Subject to the County's extension of the Lease Agreement through June 30, 2026, CalOptima staff is seeking Board authority to negotiate an extension of the existing License Agreement for the same period, and Board authority to enter into a modification and extension of the license term under the same provisions. Any modifications to insurance requirements will be reviewed by the Director of Financial Compliance, and if needed, CalOptima's broker, to confirm that CalOptima can meet the requirements and for consistency with current market practices. In the event of unanticipated substantive changes to the Lease Agreement, CalOptima will return to the Board for further authorization. The license fees and insurance expenses for the extended years will be included as part of CalOptima's annual budgeting process.

Staff recommends continuing the collaboration with the County and maintaining CalOptima's presence in the community through authorizing the Chief Executive Officer to negotiate and execute an extension and modification to the License Agreement as set forth above.

Fiscal Impact

Management will include expenses related to the terms of the extended Lease Agreement in the Fiscal Year 2022-23 and future operating budgets.

Rationale for Recommendation

As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a licensed site in central Orange County, CalOptima is able to expand services to our members and maintain a presence in the community.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Covered Entities
2. CalOptima Board Action dated February 2, 2021 Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Services Center
3. Second Amendment to Fully Executed License Agreement between CalOptima and the County of Orange

/s/ Michael Hunn — *01/27/20222*

Authorized Signature — **Date**

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Attachment to the February 3, 2022 Board of Directors Meeting – Agenda Item 4

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
The County of Orange Social Services Agency	500 N. State College Blvd.	Orange	CA	92868

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CalOptima Board Action Agenda Referral

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

Consent Calendar

6. Consider Authorizing Modification and Extension of License Agreement with the County of Orange for Use of Space at the Orange County Community Service Center Annex

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to negotiate and execute a modification of and extension to the License Agreement with the County of Orange, as amended by the First Amendment to License, for up to an additional four years through June 30, 2025 or other determined date, which allows use of approximately 362 square feet of space along with common areas at the Orange County Community Service Center Annex (OCCSCA), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683.

Background

As a public agency and community health plan that serves the Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging CalOptima members in coordination with community-based organizations, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Beginning in 2008, CalOptima utilized space at the main County Community Service Center (CCSC) office at no cost to CalOptima to offer monthly health education seminars to increase members knowledge about CalOptima and provide information to support our members' health care needs. Due to growth in membership and programs, and increased interest in the health education seminars, the space at the main office was insufficient to meet CalOptima and member needs for services at the main CCSC office. In May 2016, Orange County Social Services Agency informed CalOptima of an opportunity to expand our capacity at the CCSC office by licensing space located across the parking lot from the main CCSC office (referred to as the OCCSCA).

Effective August 5, 2016, CalOptima entered into a License Agreement for one dedicated office and access to a shared conference room for 50 percent of the time at the OCCSCA. The License at OCCSA for CalOptima's use of this space as a satellite office was effective through June 30, 2017. On June 1, 2017, CalOptima's Board of Directors authorized the CEO to extend the License Agreement for an additional four years through June 30, 2021. We are informed that the County's lease rent for July 1, 2020 – June 30, 2021 is $7,129 per month ($3.36 per square foot) for the OCCSCA space. The total leased space for the OCCSCA is comprised of 2,080 square feet, with CalOptima's use of 109 square feet for the dedicated office, 253 square feet for the shared conference room, and estimated 21 percent use of the common area. CalOptima's current License fee for July 1, 2020 through June 30, 2021 is $1,705.72 per month. CalOptima's License fee includes the use of space, as well as utilities, information technology, janitorial and telephone services. These expenses

are equivalent to approximately 24% of the County's monthly rent under the lease. The OCCSCA is centrally located in the county and may be more convenient for certain CalOptima members who reside in the cities of Santa Ana, Garden Grove and Westminster. Since September 2016, CalOptima staff has been on-site to provide information and education about CalOptima's programs and services, enhanced customer service support, and additional monthly educational seminars.

Initially, staff from various CalOptima departments rotated on-site at OCCSCA to serve members, including staff from the Behavioral Health Integration, Program of All-Inclusive Care (PACE), OneCare Connect Sales and Marketing, Customer Service and Community Relations departments. Services offered on-site include information and referrals for our programs and services, information and enrollment in the PACE and OneCare Connect programs, assistance with navigating health care benefits and customer service-related issues including provider and health network selection, referrals, and replacement ID cards.

In January 2017, CalOptima started offering New Member Orientation for our Vietnamese-speaking members at this location. Starting late May 2017, a full-time, bi-lingual Customer Service Representative was designated to the satellite office at OCCSCA to serve CalOptima members and potential members. Services expanded to include addressing billing inquiries, assisting with Protected Health Information (PHI) forms, reviewing pharmacy/medication denials and cases, filing grievances and appeals, and opening coordination of care cases.

CalOptima has also collaborated with community partners and internal departments to increase awareness and utilization of our satellite office. Since opening, CalOptima has hosted health education seminars on a monthly basis. The Population Health Management Department hosted mobile mammogram events on March 10, 2018 and October 29, 2019 in collaboration with Susan G. Komen Orange County, Orange County Health Care Agency Every Woman Counts Program and Alinea Mobile Imaging. This event targeted CalOptima Direct and CalOptima Community Network members who lived within a 5-mile radius of the satellite office and who were due for their breast cancer screening.

In addition to CalOptima's services, the OCCSCA offers a variety of health and human services to local residents including resources and referrals, application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from Orange County Health Care Agency mental health specialist and public health nurse, Orange County Housing Authority, the Family Caregiver Resource Center, the Council on Aging and the Office on Aging are available on-site to assist members.

In 2019, the total number of visitors assisted by CalOptima staff ranged from 38 to 73 individuals per month or an average of one to three per day. In March 2020, the satellite office closed due to COVID-19. To ensure the safety and well-being of our members and prevent the spread of COVID-19, health education seminars, new member orientations, workshops and events are currently on hold; however, since July 2020, CalOptima's Customer Service Representative has been able to serve our members visiting the satellite office via telephonic support. In discussions with the County regarding COVID impacts, the County has informally advised that CalOptima's use of the designated office space and

the shared space will not be impacted due to COVID-19. The County is taking steps to ensure the safety of the community and staff by implementing social distancing requirements and limiting the number of community members entering the building.

Discussion

The License Agreement, like the County's current Lease Agreement, is due to expire on June 30, 2021. While the County's current Lease Agreement includes an option to extend the term beyond June 30, 2021 for an additional four (4) year term, the CalOptima License Agreement does not. If the County extends its Lease Agreement, and CalOptima extends the License Agreement the new termination date for both agreements would be June 30, 2025. The County has until the end of February 2021 to inform the landlord of its intent to exercise its option to extend. Once exercised, the landlord and the County may begin negotiations. Due to the potential for a lengthy process for determining the rental rate, CalOptima may not know if the space will remain available, and, if so, what the monthly License fee will be until shortly before the end of the current term.

CalOptima staff is seeking Board authority to negotiate an extension of the existing License Agreement to coincide with the County's lease term, subject to the County's extension of the lease, through June 30, 2025. The Board's approval of this item would authorize CalOptima staff to have direct discussions with the County regarding its plans, if any, to extend the Lease Agreement and CalOptima's License Agreement and to begin discussions about the extensions without waiting for the County and the landlord to come to final agreement on the Lease terms. CalOptima staff is also seeking Board authority to enter into a modification and extension of the License Agreement to extend the term for up to four years under the same provisions, subject to the monthly License fee (including utility and other services currently provided) not exceeding the same proportional rate (24%) of the monthly rent negotiated between the landlord and County. Any modifications to insurance requirements will be reviewed by the Director of Financial Compliance, with the assistance of Legal Counsel, and if needed, CalOptima's broker, to confirm that CalOptima can meet the requirements and to ensure consistency with current market practices. In the event of any other material changes, CalOptima will return to the Board for further authorization. The monthly License fees and insurance expenses for the extended years are expected to be included as part of the annual budgeting process.

The licensed site establishes a valuable CalOptima presence in the community and is available to provide local access and information to members regarding CalOptima benefits and health education to support their health care needs. This office is centrally located in Orange County and provides CalOptima with an opportunity to serve our members in their community, while establishing CalOptima's presence in the community. Staff recommends authorization to negotiate with the County, and for the Chief Executive Officer, with assistance of legal counsel, authorization to execute an extension and modification to the License Agreement as set forth above. The Board's approval will allow time for staff to engage with the County and to complete any documentation necessary prior to the end of the existing term of the License Agreement.

Fiscal Impact

The current License Agreement with the County of Orange for CCSC is a budgeted item in the amount of $21,000 under the Fiscal Year (FY) 2020-21 Operating Budget approved by the Board on June 4, 2020. Funding for the recommended action to modify and extend the License Agreement through June 30, 2025, will be included in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget and future operating budgets.

Rationale for Recommendation

As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a satellite site in central Orange County, CalOptima is able to expand services to our members and maintain a local presence in the community.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated August 4, 2016 Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center.
3. CalOptima Board Action dated June 1, 2017 Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Services Center.
4. First Amendment to Fully Executed License Agreement between CalOptima and the County of Orange.
5. County of Orange Board of Supervisors Agenda Item 17-00473 dated June 6, 2017 Lease Amendment for Multi-Agency Use at 15460 and 15496 Magnolia, Westminster Attachment F Redlined Lease 15496 Magnolia

/s/ Richard Sanchez — *01/27/2021*

Authorized Signature — **Date**

Attachment to the February 4, 2021 Board of Directors Meeting – Agenda Item 6

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
The County of Orange Social Services Agency	500 N. State College Blvd.	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

36. Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center

Contact

Phil Tsunoda, Executive Director Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a one year license agreement with the County of Orange for non-exclusive use of approximately 362 square feet of space at the County Community Service Center (CCSC), located at 15496 Magnolia Street, Westminster, CA 92683; and
2. Approve allocation of $22,538 from existing reserves to fund the license agreement through June 30, 2017.

Background

The current County Community Service Center (CCSC) facility provides a variety of health and human services to local residents, including referrals for mental and public health, resources for the homeless, legal assistance, marriage licenses and passport services. The current CCSC also offers residents help to apply for Medi-Cal and Medicare. Representatives from the Health Care Agency, Social Services Agency, Office on Aging, Department of Housing, and County Clerk-Recorder Department are available on designated days.

As a public and community health plan that serves the low-income Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging our members in efforts with our community-based organization partners and through health education workshops, health fairs and seminars, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Since 2008, CalOptima has utilized available space at the current CCSC offer health education seminars. At the current CCSC location, CalOptima currently hosts one health education seminar per month to assist members about health care programs. Topics at some of the recent health education seminars have included:

- Program for All-Inclusive Care for the Elderly (PACE)
- OneCare Connect
- Medicare 2016: New Policy and Changes
- Memory Loss, Dementia, and Alzheimer's Disease
- Understanding Social Security Programs and Benefits
- Consult with Three Cardiologists: Learn about Stroke and Peripheral Arterial Disease

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While CalOptima members reside throughout Orange County, a large percentage reside in the central portion of the county. Residents in the cities of Santa Ana, Garden Grove, and Westminster comprise over 30% of CalOptima's total membership.

The current CCSC, located in the City of Westminster, has proven to be a centrally-located space for CalOptima members to attend health education seminars, and obtain information about programs and services. In conjunction with services offered by various county departments, the County of Orange provided CalOptima with use of the CCSC at no cost as a service to community residents.

Due to CalOptima's growth in membership and programs, and the resulting increase in interest in CalOptima's health education seminars at CCSC, additional space would better accommodate the needs of CalOptima members. At recent seminars, members have been turned away due to lack of space. While staff has addressed this issue in the short term by hosting multiple seminar sessions on the same day, the current space presents logistical challenges.

Earlier this year, the County of Orange informed CalOptima of its decision to expand capacity at the CCSC by leasing additional space located across the parking lot from the existing facility effective July 1, 2016 for use by the Orange County Social Services Agency. The leased space would provide the County with expanded space for its programs and also provide CalOptima with the opportunity to enter into a license agreement with the County that would provide CalOptima with a dedicated office, as well as shared use of a conference room space in order to offer more health education seminars and other community events each month.

Discussion

Staff recommends authorization of the license agreement with the County of Orange, which would allow CalOptima to have one dedicated office, along with shared use of a conference room. The County's recently added CCSC space has a conference room (which is 253 square feet in size) that is adjacent to the entryway of the suite. Additionally, the County of Orange is proposing to remove the wall between the conference room and the entryway (at CalOptima's expense), which would create a larger space for community events, such as the health education seminars. While the original CCSC has a maximum capacity to hold events with 20 participants, the new CCSC space will have the capacity to hold events with approximately 50 participants.

The County's newly leased CCSC space is comprised of 2,080 square feet total. The County's primary lease agreement with the property owner is for $5,000 per month (approximately $2.40 per square foot) and includes seven offices as well as a conference room. As proposed, CalOptima would have access to the conference room for 50% of the time, one dedicated office, and the common area of the leased space.

Based on estimates provided by the County of Orange, the monthly expenses to CalOptima for its portion of the space is $1,453.02. This cost estimate is based on: 253 square footage of conference room space, 109 square foot dedicated CalOptima office, and prorated 21% of total common area. The County of Orange estimates the improvement costs to remove the wall between the conference room and the entryway at $7,646 in one-time costs to CalOptima.

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Staff has conducted a review of the County of Orange's sub-lease agreement. Based on current commercial real estate trends, the proposed license is well within market pricing.

	Total Amount
License Fee (August 2016 - June 2017) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$14,892
Improvement costs (Removal of wall)	$7,646
Total	**$22,538**

The County of Orange's primary lease agreement for the annexed CCSC is for the period of July 1, 2016 through June 30, 2017. Staff is proposing CalOptima's license for the CCSC annex to be for the period of August 5, 2016 through June 30, 2017.

Fiscal Impact
The recommended action to execute a license agreement with the County of Orange through June 30, 2017, for usage of space at the CCSC will be funded through an allocation of $22,538 from existing reserves.

Rationale for Recommendation
As part of CalOptima's mission, staff works towards providing access to health care services for our members. In the past eight years, CalOptima's participation at the CCSC has proved extremely valuable, as we have helped provide access to information about programs and benefits, as well as critical health education to members. Due to CalOptima's new programs and substantial increase in overall membership, the current CCSC location no longer meets the needs of our members. The opportunity to partner with the County of Orange and sub-lease additional space, provides a low-cost solution to not only meet the existing logistical challenges of the health education seminars, but also provides an opportunity for CalOptima to expand its services to members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Draft County of Orange CCSC Annex Proposed License Agreement with CalOptima for new CCSC location
2. CCSC Cost Apply
3. County of Orange Primary Lease Agreement for new CCSC location
4. Quotation for Tenant Improvements

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

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LICENSE AGREEMENT

This LICENSE AGREEMENT (**"License"**) is made and entered into _____ , 2016 (**"Effective Date"**), by and between, CALOPTIMA, (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property"**) pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The Services provided by LICENSEE will include a convenient on-site source while SSA clients are at the SSA Office.

III. COUNTY agrees to provide LICENSEE sufficient office space within the SSA Office for LICENSEE to provide the Services.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, COUNTY and LICENSEE do hereby agree as follows:

1. DEFINITIONS (AMLC-2.1 S)

The following words in this License have the significance attached to them in this clause, unless otherwise apparent from context:

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"Chief Real Estate Officer" means the Chief Real Estate Officer, County Executive Office, County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"**Facilities Services Manager**" means the Manager of the Social Services Agency, Facilities Services, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Director of Social Services Agency.

"Risk Manager" means the Manager of County Executive Office, Risk Management, for the County of Orange, or upon written notice to LICENSEE, such entity as shall be designated by the County Executive Officer.

"SSA Director" means the Director of Social Services Agency, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. TERM (AMLC-3.1 N)

The term of this License shall commence on the Effective Date and terminate on June 30, 2017, unless terminated as provided in Clause 3 (TERMINATION) of this License.

3. TERMINATION (AMLC-3.3 S)

This License shall be revocable by either COUNTY's SSA Director or LICENSEE at any time; however, as a courtesy the Parties will attempt to give thirty (30) days written notice to the other Party upon revocation.

4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the non-exclusive right to use that certain property hereinafter referred to as **"License Area,"** shown on Exhibit A, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of the License Area will be determined by the Facilities Services Manager, and the location of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

5. PARKING (AMLC-4.4 S)

Throughout the term of this License COUNTY shall provide one (1) parking space for LICENSEE's free and non-exclusive use.

6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their Medi-Cal benefits.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

NO ALCOHOLIC BEVERAGES OR TOBACCO PRODUCTS SHALL BE SOLD OR CONSUMED WITHIN THE LICENSE AREA.

7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the effective date of this License according to the following schedule:

MONTH	MONTHLY LICENSE FEE
1	$0.00
2	$361.73
3	$1,453.02
4	$1,453.02
5	$1,453.02
6	$1,453.02
7	$1,453.02
8	$1,453.02
9	$1,453.02
10	$1,453.02
11	$1,453.02
12	$1,453.02

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month. The fee for any partial calendar month during which this License becomes effective will be payable on such effective date.

8. PAYMENT PROCEDURE (AMLC-7.1 N)

All payments shall be delivered to the County of Orange, Office of the Auditor-Controller, P. O. Box 567 (630 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any time by COUNTY upon ten (10) days written notice to LICENSEE. License Fee payments may be made by check payable to the County of Orange. Said License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee for office space at the Orange County Community Service Center Annex in Westminster, California. A duplicate copy of the payment voucher shall be mailed to the County of Orange, Social Services Agency, 500 N. State College Boulevard, Orange, California,

92868, Attention: Facilities Services Manager. LICENSEE assumes all risk of loss if payments are made by mail.

No payment by LICENSEE or receipt by COUNTY of a lesser amount than the payment due shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction, and COUNTY shall accept such check or payment without prejudice to COUNTY's right to recover the balance of said payment or pursue any other remedy in this License.

9. CHARGE FOR LATE PAYMENT (AMLC-7.2 S)

LICENSEE hereby acknowledges that late payment of sums due hereunder will cause COUNTY to incur costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include but are not limited to costs such as administrative processing of delinquent notices, increased accounting costs, etc.

Accordingly, if any payment pursuant to this license is not received by COUNTY by the due date, a late charge of one and one-half percent (1.5%) of the payment due and unpaid plus $100 shall be added to the payment, and the total sum shall become immediately due and payable to the COUNTY. An additional charge of one and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

LICENSEE and COUNTY hereby agree that such late charges represent a fair and reasonable estimate of the costs that COUNTY will incur by reason of LICENSEE's late payment.

Acceptance of such late charges (and/or any portion of the overdue payment) by COUNTY shall in no event constitute a waiver of LICENSEE's default with respect to such overdue payment, or prevent COUNTY from exercising any of the other rights and remedies granted hereunder.

10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas and sewer),. County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). COUNTY shall be responsible for telephone service, internet service and janitorial service. All charges for services provided by COUNTY pursuant to this Clause shall be included in LICENSEE's "MONTHLY LICENSE FEE" pursuant to Clause 7. (LICENSE FEE) of the License.

11. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (AMD2.1 S)

COUNTY's Consent. No structures, improvements, or facilities shall be constructed, erected, altered, or made by LICENSEE within the License Area without prior written consent of the Facilities Services Manager. Any conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the Facilities Services Manager as a condition to granting such consent, shall be conditions hereof as though originally stated herein. LICENSEE may, at any time and at its sole expense, install and place business fixtures and equipment within License Area.

Strict Compliance with Plans and Specifications. All improvements constructed by LICENSEE within the

License Area shall be constructed in strict compliance with detailed plans and specifications approved by the Facilities Services Manager.

COUNTY shall contract with a licensed contractor to remove the existing wall between the "Reception Area" and "Room #1" as depicted in Exhibit B, to replace existing carpet, and repair any areas resulting from removing said wall. LICENSEE shall reimburse COUNTY in the amount not to exceed Seven Thousand six hundred forty-five dollars and fifty-five cents ($7,645.55) within twenty (20) business days of COUNTY's submittal to LICENSEE of an invoice from COUNTY.

12. MECHANICS LIENS OR STOP-NOTICES (AMD4.1 S)

LICENSEE shall at all times indemnify, defend with counsel approved in writing by COUNTY and save COUNTY harmless from all claims, losses, demands, damages, cost, expenses, or liability costs for labor or materials in connection with construction, repair, alteration, or installation of structures, improvements, equipment, or facilities within the License Area, and from the cost of defending against such claims, including attorney fees and costs.

In the event a lien or stop-notice is imposed upon the License Area as a result of such construction, repair, alteration, or installation, LICENSEE shall either:

A. Record a valid Release of Lien, or

B. Procure and record a bond in accordance with Section 3143 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

Should LICENSEE fail to accomplish either of the two optional actions above within fifteen (15) days after the filing of such a lien or stop-notice, the License shall be in default and shall be subject to immediate termination.

13. OWNERSHIP OF IMPROVEMENTS (AMD6.1 N)

All improvements, exclusive of trade fixtures, constructed or placed within the License Area by LICENSEE must, upon completion, be free and clear all liens, claims, or liability for labor or material and at COUNTY's option shall be the property of COUNTY's at the expiration of this License or upon earlier termination hereof. COUNTY retains the right to require LICENSEE, at LICENSEE's cost, to remove all LICENSEE's improvements located on the License Area at the expiration or termination hereof.

14. INSURANCE (AML10.1 N)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with COUNTY during the entire term of this License. This License shall automatically terminate at the same time LICENSEE's insurance coverage is terminated. If within ten (10) business days after termination under this Clause LICENSEE obtains and provides evidence of the required insurance coverage acceptable to Facilities Services Manager, this License may be reinstated at the sole discretion of Facilities Services Manager.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Services Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Services Manager will only accept valid certificates of insurance and

endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Services Manager reinstates the License.

If LICENSEE fails to provide Facilities Services Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Services Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by COUNTY from LICENSEE under this License. It is the obligation of LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.
All self-insured retentions (**"SIRs"**) and deductibles shall be clearly stated on the Certificate of Insurance. If no SIRs or deductibles apply, indicate this on the Certificate of Insurance with a "0" by the appropriate line of coverage. Any **SIR** or deductible in excess of $25,000 ($5,000 for automobile liability), shall specifically be approved by COUNTY's Risk Manager.

If LICENSEE fails to maintain insurance acceptable to COUNTY for the full term of this License, COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer licensed to do business in the state of California (California Admitted Carrier) or have a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category) as determined by the most current edition of the **Best's key Rating Guide/Property-Casualty/United States or ambest.com**.

If the insurance carrier is not an admitted carrier in the state of California and does not have an A.M. Best rating of A-/VIII, COUNTY's Risk Manager retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (**"ISO"**) form CG 00 01, or a substitute form providing liability coverage at least as broad.
The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The following endorsements must be submitted with the Certificate of Insurance:

a) The Commercial General Liability policy shall contain an Additional Insured endorsement using ISO form CG 2010 or CG 2033 or a form at least as broad naming the COUNTY, its elected and appointed officials, officers, employees, and agents as Additional Insureds.

b) The Commercial General Liability policy shall contain a primary non-contributing endorsement evidencing that the LESSEE's insurance is primary and any insurance or self-insurance maintained by the COUNTY shall be excess and non-contributing.

c) The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the COUNTY, and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees.

d) The Commercial Property policy shall contain a Loss Payee endorsement naming the COUNTY as respects the COUNTY's financial interest when applicable.

All insurance policies required by this contract shall waive all rights of subrogation against the COUNTY and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

All insurance policies required by this contract shall give COUNTY thirty (30) days notice in the event of cancellation and ten (10) days for non-payment of premium. This shall be evidenced by policy provisions or an endorsement separate from the Certificate of Insurance.

The Commercial General Liability policy shall contain a severability of interests' clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to COUNTY's address provided in Clause 17 (NOTICES) below or to an address provided by SSA/Facilities Services Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by COUNTY's Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

15. OPERATIONS (AMLC-11.1 N)

LICENSEE shall keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair. COUNTY will, on LICENSEE's behalf, provide all maintenance and repairs to the License Area during the term of the License. LICENSEE is required to notify COUNTY of any and all necessary maintenance and repairs to the License Area on a timely basis.

LICENSEE expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary condition, to the complete satisfaction of COUNTY and in compliance with all applicable laws. LICENSEE further agrees to keep the License Area free and clear of rubbish and litter. COUNTY shall have the right to enter upon and inspect the License Area at any time for cleanliness and safety.

LICENSEE shall designate in writing to COUNTY an on-site representative who shall be responsible for the day to day operation and level of maintenance, cleanliness, and general order.

16. LIMITATION OF THE LICENSE (AMLC-13.1 S)

This License and the rights and privileges granted LICENSEE in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to LICENSEE of rights in the License Area, which exceed those owned by COUNTY.

17. HIPAA NOTICE (N)

LICENSEE acknowledges that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires COUNTY to safeguard and maintain the confidentiality of any Protected Health Information (PHI). LICENSEE hereby agrees not to access, remove, destroy, or relocate any property used by COUNTY to safeguard and store PHI. LICENSEE further agrees to use appropriate safeguards and to

take all reasonable steps to prevent access to any PHI stored on the premises, including informing its workforce, contractors and vendors of the confidential nature of the records maintained by COUNTY. LICENSEE agrees to report to COUNTY within ten (10) calendar days any unauthorized use or any disclosure of PHI, which LICENSEE becomes aware. Upon COUNTY's knowledge of any breach, disclosure, or unauthorized use of PHI by LICENSEE, COUNTY shall:

a. Provide an opportunity for LICENSEE to cure the breach or end the violation. If LICENSEE does not cure the breach or end the violation within thirty (30) days or shorter period as required by COUNTY, COUNTY shall terminate this Agreement; or

b. Immediately terminate this Agreement if cure is not possible.

18. HAZARDOUS MATERIALS (AMLC-16.1 S)

A. Definition of Hazardous Materials. For purposes of this License, the term **"Hazardous Material"** or "Hazardous Materials" shall mean any hazardous or toxic substance, material, product, byproduct, or waste which is or shall become regulated by any governmental entity, including, without limitation, the COUNTY acting in its governmental capacity, the State of California or the United States government.

B. Use of Hazardous Materials. LICENSEE or LICENSEE's employees, agents, independent contractors or invitees (collectively **"LICENSEE Parties"**) shall not cause or permit any Hazardous Materials to be brought upon, stored, kept, used, generated, released into the environment or disposed of on, under, from or about the License Area (which for purposes of this clause shall include the subsurface soil and ground water). Notwithstanding the foregoing, LICENSEE may keep on or about the License Area small quantities of Hazardous Materials that are used in the ordinary, customary and lawful cleaning of and business operations on the License Area.

C. LICENSEE Obligations. If the presence of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties results in (i) injury to any person, (ii) injury to or contamination of the License Area (or a portion thereof), or (iii) injury to or contamination or any real or personal property wherever situated, LICENSEE, at its sole cost and expense, shall promptly take all actions necessary or appropriate to return the License Area to the condition existing prior to the introduction of such Hazardous Materials to the License Area and to remedy or repair any such injury or contamination. Without limiting any other rights or remedies of COUNTY under this License, LICENSEE shall pay the cost of any cleanup or remedial work performed on, under, or about the License Area as required by this License or by applicable laws in connection with the removal, disposal, neutralization or other treatment of such Hazardous Materials caused or permitted by LICENSEE or LICENSEE Parties. Notwithstanding the foregoing, LICENSEE shall not take any remedial action in response to the presence, discharge or release, of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties, or enter into any settlement agreement, consent decree or other compromise with any governmental or quasigovernmental entity without first obtaining the prior written consent of the COUNTY. All work performed or caused to be performed by LICENSEE as provided for above shall be done in good and workmanlike manner and in compliance with plans, specifications, permits and other requirements for such work approved by COUNTY.

D. Indemnification for Hazardous Materials. To the fullest extent permitted by law, LICENSEE hereby agrees to indemnify, hold harmless, protect and defend (with attorneys acceptable to COUNTY) COUNTY, its elected officials, officers, employees, agents and independent contractors and the

License Area, from and against any and all liabilities, losses, damages (including, but not limited, damages for the loss or restriction on use of rentable or usable space or any amenity of the License Area or damages arising from any adverse impact on marketing of the License Area), diminution in the value of the License Area, judgments, fines, demands, claims, recoveries, deficiencies, costs and expenses (including, but not limited to, reasonable attorneys' fees, disbursements and court costs and all other professional or consultant's expenses), whether foreseeable or unforeseeable, arising directly or indirectly out of the presence, use, generation, storage, treatment, on or off-site disposal or transportation of Hazardous Materials on, into, from, under or about the License Area by LICENSEE or LICENSEE's Parties. The foregoing indemnity shall also specifically include the cost of any required or necessary repair, restoration, clean-up or detoxification of the License Area and the preparation of any closure or other required plans.

19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to have been given upon receipt.

TO: COUNTY

County of Orange
Social Services Agency
Facilities Services
500 N. State College Boulevard
Orange, CA 92868

With a copy to:

County Executive Office
Attention: Chief Real Estate Officer
333 W. Santa Ana Boulevard, 3rd Floor
Santa Ana, CA 92701

TO: LICENSEE

CalOptima
15496 Magnolia, #111
Westminster, CA 92806
Phil Tsunoda, Executive Director,
Public Policy & Public Affairs
ptsunoda@caloptima.org

20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Exhibit A - License Description
Exhibit B – Floor Plan

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WITNESS WHEREOF, the parties have executed this License the day and year first above written.

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By_____
Deputy County Counsel

Date:_____

LICENSEE
CalOptima

By_____

Name:_____
Title:_____

RECOMMENDED FOR APPROVAL

Social Services Agency

By_____
Carol Wiseman, Chief Deputy Director

CEO Real Estate Services

By_____
John Beck, Administrative Manager

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date:_____

GENERAL CONDITIONS (AMLC-GC l-17 S)

1. PERMITS AND LICENSES (AMLC - GC2 S)

LICENSEE shall be required to obtain any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by COUNTY, in its governmental capacity, shall affect or limit LICENSEE's obligations hereunder, nor shall any approvals or consents given by COUNTY, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

2. SIGNS (AMLC-GC3 S)

LICENSEE agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by Facilities Operations Manager unapproved signs, banners, flags, etc., may be removed.

3. LICENSE ORGANIZATION (AMLC-GC4 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

4. AMENDMENTS (AMLC-GC5 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

5. UNLAWFUL USE (AMLC-GC6 S)

LICENSEE agrees no improvements shall be erected, placed upon, operated, nor maintained on the License Area, nor any business conducted or carried on therein or there from, in violation of the terms of this License, or of any regulation, order of law, statute, bylaw, or ordinance of a governmental agency having jurisdiction.

6. INSPECTION (AMLC-GC7 S)

COUNTY or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

7. INDEMNIFICATION (AMLC-GC8 S)

LICENSEE hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of persons or property arising from, growing out of, or in any way connected with or related to this License except claims arising from the concurrent active or sole negligence of COUNTY, its officers, agents, and employees. LICENSEE hereby agrees to indemnify, hold harmless, and defend with counsel acceptable to COUNTY, its officers, agents, and employees against any and all claims, loss, demands, damages, cost, expenses, or liability costs arising out of the operation, use, or maintenance of the property

described herein, and/or LICENSEE's exercise of the rights under this License, except for liability arising out of the concurrent active or sole negligence of COUNTY, its officers, agents, or employees, including the cost of defense of any lawsuit arising there from.

In the event COUNTY is named as co-defendant, LICENSEE shall notify COUNTY of such fact and shall represent COUNTY with counsel acceptable to COUNTY in such legal action unless COUNTY undertakes to represent itself as co-defendant in such legal action, in which event LICENSEE shall pay to COUNTY its litigation costs, expenses, and attorney's fees. In the event judgment is entered against COUNTY and LICENSEE because of the concurrent active negligence of COUNTY and LICENSEE, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

8. TAXES AND ASSESSMENTS (AMLC-GC9 S)

Although not anticipated, should this License create a possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all taxes and assessments (including but not limited to said possessory interest tax) which become due and payable in connection with this License or upon fixtures, equipment, or other property used in connection with this License, shall be the full responsibility of LICENSEE, and LICENSEE shall cause said taxes and assessments to be paid promptly.

9. PARTIAL INVALIDITY (AMLC-GC10 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

10. WAIVER OF RIGHTS (AMLC-GC11 S)

The failure of COUNTY to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that COUNTY may have, and shall not be deemed a waiver of the right to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

11. CONDITION OF LICENSE AREA UPON TERMINATION (AMLC-GC12 S)

Except as otherwise agreed to herein, upon termination of this License, LICENSEE shall redeliver possession of said License Area to COUNTY in substantially the same condition that existed immediately prior to LICENSEE’s entry thereon, reasonable wear and tear, flood, earthquakes, and any act of war excepted.

12. DISPOSITION OF ABANDONED PERSONAL PROPERTY (AMLC-GC13 S)

If LICENSEE abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to LICENSEE and left on the License Area ten (10) days after such event shall be deemed, at COUNTY’s option, to have been transferred to COUNTY. COUNTY shall have the

right to remove and to dispose of such property without liability there from to LICENSEE or to any person claiming under LICENSEE, and shall have no need to account therefore.

13. TIME OF ESSENCE (AMLC-GC14 S)

Time is of the essence of this License. Failure to comply with any time requirements of this License shall constitute a material breach of this License.

14. NO ASSIGNMENT (AMLC-G15 S)

The License granted hereby is personal to LICENSEE and any assignment of said license by LICENSEE, voluntarily or by operation of law, shall automatically terminate the License granted hereby.

15. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (AMLC-GC16 S)

In order to comply with child support requirements of the County of Orange, LICENSEE hereby furnishes COUNTY's Facilities Operations Manager, COUNTY's standard form, Child Support Enforcement Certification Requirements. COUNTY acknowledges receipt of the aforementioned form, which contains the following information:

a) In the case where LICENSEE is doing business as an individual, LICENSEE's name, date of birth, Social Security number, and residence address;

b) In the case where LICENSEE is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

c) A certification that LICENSEE has fully complied with all applicable federal and state reporting requirements regarding its employees; and

d) A certification that LICENSEE has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to so comply.

Failure of LICENSEE to continuously comply with all federal and state reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this License. Failure to cure such breach within sixty (60) calendar days of notice from COUNTY's shall constitute grounds for termination of this License.

It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.

16. RIGHT TO WORK AND MINIMUM WAGE LAWS (AMLC-GC17 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LICENSEE shall require its employees that directly or indirectly service the License Area or terms and conditions of this License, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LICENSEE shall also require and verify that its contractors or any other persons servicing the License Area

or terms and conditions of this License, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LICENSEE shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. LICENSEE shall require and verify that all its contractors or other persons servicing the License Area on behalf of LICENSEE also pay their employees no less than the greater of the Federal or California Minimum Wage.

LICENSEE shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the License Area or terms and conditions of this License.

Notwithstanding the minimum wage requirements provided for in this clause, LICENSEE, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

17. BEST MANAGEMENT PRACTICES (AMLC 15.1 S)

LICENSEE and all of LICENSEE's, agents, employees and contractors shall conduct operations under this License so as to assure that pollutants do not enter municipal storm drain systems which systems are comprised of, but are not limited to curbs and gutters that are part of the street systems ("**Stormwater Drainage System**"), and to ensure that pollutants do not directly impact "**Receiving Waters**" (as used herein, Receiving Waters include, but are not limited to, rivers, creeks, streams, estuaries, lakes, harbors, bays and oceans).

The Santa Ana and San Diego Regional Water Quality Control Boards have issued National Pollutant Discharge Elimination System ("**NPDES**") permits ("**Stormwater Permits**") to the County of Orange, and to the Orange County Flood Control District and cities within Orange County, as co-permittees (hereinafter collectively referred to as "**County Parties**") which regulate the discharge of urban runoff from areas within the County of Orange, including the License Area. The County Parties have enacted water quality ordinances that prohibit conditions and activities that may result in polluted runoff being discharged into the Stormwater Drainage System.

To assure compliance with the Stormwater Permits and water quality ordinances, the County Parties have developed a Drainage Area Management Plan ("**DAMP**") which includes a Local Implementation Plan ("**LIP**") for each jurisdiction that contains Best Management Practices ("**BMP(s)**") that parties using properties within Orange County must adhere to. As used herein, a BMP is defined as a technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in a cost effective manner. These BMPs are found within the COUNTY's LIP in the form of Model Maintenance Procedures and BMP Fact Sheets (the Model Maintenance Procedures and BMP Fact Sheets contained in the DAMP/LIP shall be referred to hereinafter collectively as "**BMP Fact Sheets**") and contain pollution prevention and source control techniques to eliminate non-stormwater discharges and minimize the impact of pollutants on stormwater runoff.

The use under this License does not require BMP Fact Sheets.

18. PAYMENT CARD COMPLIANCE (AMLC-G15 S)

Should LICENSEE conduct credit/debit card transactions in conjunction with their business with the COUNTY, on behalf of the COUNTY, or as part of the business that they conduct, LICENSEE covenants and warrants that it is currently Payment Card Industry Data Security Standard (**"PCI DSS"**) and Payment Application Data Security Standards (**"PA DSS"**) compliant and will remain compliant during the entire duration of this License. LICENSEE agrees to immediately notify COUNTY in the event LICENSEE should ever become non-compliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

Upon demand by COUNTY, LICENSEE shall provide to COUNTY written certification of LICENSEE's PCI DSS and/or PA DSS compliance.

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LICENSE DESCRIPTION (10.1 S)

PROJECT NO: GA 1213-236 DATE: 6/29/16

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

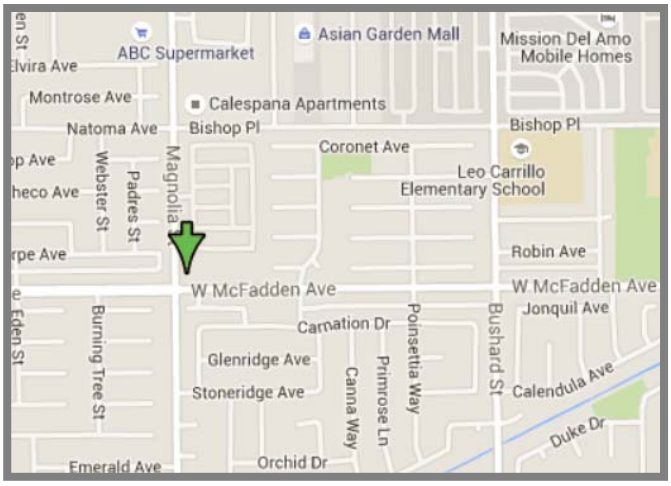
WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's non-exclusive use, which space may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT A

GA 1213-237
SSA/CalOptima



Location Map

N

License Area:
Rooms 1 & 2

EXHIBIT B

Reception Area

CCSC COST APPLY - 15496 Magnolia Street, Westminster

FY 2016-17 MONTHLY INVOICE CODING SUMMARY

Invoice Coding and Job Number Allocation.

	Fund/Dept/Budget Control Unit/Object/Job No.	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency/Partners	100/063/063 2211/2200/ S34000	$ 656.94	$ 295.21	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	**$ 12,117.85**
Clerk-Recorder	100/063/063 2211/2200/ S34006	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Health Care Agency	100/063/063 2211/2200/ S34007	$ 1,278.26	$ 1,278.26	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	**$ 46,212.65**
OC Community Resources	100/063/063 2211/2200/ S34008	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
CalOptima	100/063/063 2211/2200/S34009	$ -	$ 361.73	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	**$ 14,891.90**
		$ 1,935.20	**$ 1,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 73,222.40**

LEASED SPACE

	sq ft	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**177.25**	**16.43%**	**$ 251.40**	**$ 107.96**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 9,652.58**
Health Care Agency - Total	**666.25**	**61.75%**	**$ 405.80**	**$ 405.80**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 35,743.11**
- Environmental Health	379.05	35.13%	$ 230.87	$ 230.87	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	20,335.35
- AMHS	232.7	21.57%	$ 141.73	$ 141.73	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	12,483.93
- Public Health Nursing	54.5	5.05%	$ 33.19	$ 33.19	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	2,923.83
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**235.5**	**21.83%**	**$ -**	**$ 143.44**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 12,490.71**
					$ -										
TOTAL	**1079**	**100%**	**$ 657.20**	**$ 657.20**	**$ 5,000.00**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 57,886.40**

Total leased space: 2080 sq. ft.

Lease rates:	Monthly	Fiscal Year total:
Rent: September 1, 2016 - September 30, 2017	$ 5,000.00	$ 50,000.00
Operating Expenses: July 1 2016- June 30, 2017	$ 657.20	$ 7,886.40

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IT SERVICES

	# computers	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**1**	**12.50%**	**$ 96.25**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 625.63**
Health Care Agency - Total	**6**	**75.00%**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 3,465.00**
- Environmental Health	5	$ 0.63	$ 240.63	$ 240.63	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	$ 2,887.50
- AMHS	0.5	$ 0.06	$ 24.06	$ 24.06	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	$ 288.75
- Public Health Nursing	0.5	$ 0.06	$ 24.06	$ 24.06	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	$ 288.75
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**12.50%**	**$ -**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 529.38**
TOTAL	**8**	**100%**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 4,620.00**

Monthly IT rates	$ 385.00
Annual Telephone Service Costs	$ 4,620.00

TELEPHONE SERVICES

	# phones	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**1**	**16.67%**	**$ 39.33**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 255.67**
Health Care Agency - Total	**4**	**66.67%**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 944.00**
- Environmental Health	3	50.00%	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 708.00
- AMHS	0.5	8.33%	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 118.00
- Public Health Nursing	0.5	8.33%	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 118.00
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**16.67%**	**$ -**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 216.33**
TOTAL	**6**	**100%**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 1,416.00**

Monthly Telephone Service Costs	$ 118.00
Annual Telephone Service Costs	$ 1,416.00

JANITORIAL SERVICES

	sq ft	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total

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Annex - 15496 Magnolia Ave, CCSC

Previous site amount	Variance
$ 11,476.51	$34,736.14

Total Annual Charges - check

$ 70,822.40

CODING

SSA INVOICE				Cost Apply - Other Agency			
Fund/Dept/Budget Control	Unit	Object	Job #	Fund/Dept/Budget Control	Unit	Object	Job #
100/063/063	2211	2200	S34000	--	--	--	--
100/063/063	2211	2200	S34007	See below			
See above				100/042/042	6600	2200	H4046800
See above				100/042/042	2100	2200	H2407N70
See above				100/042/042	1520	2200	H1120800
100/063/063	2211	2200	S34006	100/059/059	--	2200	PCW002
100/063/063	2211	2200	S34008	See below			
	2211	2200	S34009	NA - will be invoiced			
Default SSA coding	--	--	--	--	--	--	--
100/063/063	2211	2200	S34000	--	--	--	--

Lease, Janitorial & Utility Allocation	sq ft	Allocation %
Social Services Agency	177.25	16.427%
Health Care Agency	666.25	61.747%
- Environmental	379.05	35.130%
- AMHS	232.7	21.566%
- Public Health	54.5	5.051%
Clerk-Recorder	0	0.000%
OC Community Resources	0	0.000%
CalOptima	235.5	21.826%
TOTAL	1079	161.7%

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West Annex Community Customer Service Center
15496 Magnolia Street
Westminster, CA 92683

LEASE

THIS IS A LEASE (hereinafter referred to as "**Lease**"), made July 1, 2016, ("**Effective Date**") by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006 ("**LESSOR**") and the COUNTY OF ORANGE, a political subdivision of the State of California ("**COUNTY**"), without regard to number and gender. The LESSOR and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**.

1. DEFINITIONS (1.2 S)

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"CEO Real Estate"" means the County Executive Office's Real Estate team, or upon written notice to LESSOR, such other person or entity as shall be designated by the Chief Real Estate Officer, County of Orange, or designee.

"Chief Real Estate Officer" means the Chief Real Estate Officer for the County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or r the Board of Supervisors.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"Risk Manager" means the Risk Manager, County Executive Office, Risk Management, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. PREMISES (1.3 S)

LESSOR leases to COUNTY that certain property consisting of 2,120 square feet, located at 15496 Magnolia Street, Suite 111, Westminster, CA and described in Exhibit A and shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as "**Premises**"),, together with non-exclusive, in common use of LESSOR's elevators, stairways, washrooms, hallways, parking areas, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to the Premises created by this Lease.

3. PARKING (1.4 S)

LESSOR, throughout the term of this Lease, shall provide a total of thirteen (13) parking spaces for COUNTY's free and non-exclusive use. Said parking spaces are to be located in the parking areas adjacent to the Premises. LESSOR shall designate three (3) parking spaces adjacent to the Premises to be reserved for use by COUNTY clients. Said parking spaces shall contain signs above the space indicating that the spaces are reserved for COUNTY use.

In addition to said parking spaces, LESSOR shall also provide parking for disabled persons in accordance with the Americans with Disabilities Act, Section 7102 of the California Uniform Building Code and the applicable codes and/or ordinances relating to parking for disabled persons as established by the local jurisdiction in which the Premises is located where the provisions of such local codes and/or ordinances exceed or supersede the State requirements.

4. TERM (2.2 N)

The term of this Lease shall be one (1) year ("**Term**"), commencing upon the first of the next month following execution of this Lease by the COUNTY Chief Real Estate Officer or upon LESSOR's delivery and COUNTY's acceptance of the Premises, whichever is later ("**Commencement Date**").
Parties agree that the Commencement Date of this Lease will be confirmed in writing by either Party upon demand by the other.

5. RENT (3.1 N)

COUNTY agrees to pay LESSOR as rent for the Premises the sum of Five Thousand Dollars ($5,000.00) per month pursuant to the following rent payment schedule ("**Rent**").

MONTH	MONTHLY RENT	MONTH	MONTHLY RENT
1	$0.00	7	$5,000.00
2	$0.00	8	$5,000.00
3	$5,000.00	9	$5,000.00
4	$5,000.00	10	$5,000.00
5	$5,000.00	11	$5,000.00
6	$5,000.00	12	$5,000.00

To obtain rent payments LESSOR (or LESSOR's designee) shall submit to the COUNTY, in a form acceptable to said COUNTY, a written claim for payment of applicable Rent and COUNTY's share of the NNN Expenses, as defined in Section 6, below.

Payment shall be due and payable by direct deposit into a bank account specified by LESSOR within twenty (20) days after the later of the following:

A. The first day of the month following the month earned; or
B. Receipt of LESSOR's written claim by COUNTY.

Should COUNTY occupy the Premises before the Commencement Date, LESSOR shall be entitled to pro rata Rent for the period of occupancy occupied prior to the Commencement Date based upon the monthly Rent above. Said Rent shall be included in the rent claim submitted by LESSOR for the first full month of the Term and shall be paid by COUNTY at the time of payment for said month.

6. REIMBURSEMENT OF LESSOR'S OPERATING EXPENSES (6.0 N)

LESSOR and COUNTY agree pursuant to Section 5, above, that COUNTY shall pay the fixed amount of $657.20 ($.31/sf/mo.) per month for the term of the lease, as reimbursement for COUNTY's pro rata share of LESSOR's expenses related to the items described in Section 6A, 6B, 6C and 6D of this Lease for the property in which the Premises is located ("**NNN Expenses**"). LESSOR shall submit to COUNTY a separate monthly invoice .in addition to the monthly Rent invoice.

The pro rata share of LESSOR's NNN Expenses as defined above is determined according to the gross leasable area of the Premises as it relates to the total gross leasable area of the building that contains the Premises. The percent of COUNTY's occupancy which LESSOR and COUNTY agree is 12.47% (the "**pro rata share**"): the Premises is 2,120 gross square feet; and the total building area is 17,000 gross square feet.

COUNTY shall reimburse LESSOR for COUNTY's pro rata share of the NNN Expenses only for the items in Section 6A, 6B and 6C and 6D below:

A. Property Taxes and Property Tax Assessments pursuant to Section 13 of this Lease.
B. Maintenance and repair, and janitorial services for the common area restrooms in the building in which the Premises is located pursuant to Section 9 of this Lease.
C. Common area maintenance and repair of the building, parking lots, landscaping, lighting, and other common area maintenance and repair costs pursuant to Section 9 of this Lease.
D. Commercial Property Insurance and Commercial General Liability Insurance pursuant to Section 11 of this Lease.

7. ALTERATIONS (4.4 S)

COUNTY may make improvements and changes in the Premises, including but not limited to the installation of fixtures, partitions, counters, shelving, and equipment as deemed necessary or appropriate. It is agreed that any such fixtures, partitions, counters, shelving, or equipment attached to or placed upon the Premises by COUNTY shall be considered as personal property of COUNTY, who shall have the right to remove same. COUNTY agrees that the Premises shall be left in as good condition as when received, reasonable wear and tear excepted.

8. ORANGE COUNTY INFROMATION TECHNOLOGY SYSTEM S (OCIT) (4.5 N)

LESSOR agrees that COUNTY may install, at COUNTY's sole cost and expense, computer and telecommunication devices in, on, or around the Premises and LESSOR's building in accordance with COUNTY's plans and specifications provided that the provisions of the Clause entitled ALTERATIONS, of this Lease, shall be applicable to such work. It shall be COUNTY's responsibility to obtain all governmental permits and/or approvals required for such installation; however, LESSOR shall reasonably cooperate with COUNTY as necessary or appropriate, to obtain said permits and/or approvals.

9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 N)

LESSOR shall keep, maintain, and repair the building and other improvements upon the Premises in good and sanitary order and condition (except as otherwise provided in this Lease) including without limitation, the maintenance and repair of the roof, parking lot, sidewalks, common area restrooms including janitorial supplies and services, landscaping, store front, doors, window casements, glazing, plumbing, pipes, electrical wiring, and conduits, and the heating and air conditioning system including the maintenance of a service contract with a heating and air conditioning contractor, as necessary to maintain the property in

which the Premises is located in good and sanitary order, condition, and repair. COUNTY shall reimburse LESSOR for the County's pro rata share of said expenses in accordance with Section 6 of the Lease. Notwithstanding the language in the paragraph above, COUNTY shall provide at its own cost and expense all repair and maintenance and services to the interior of the Premises.

A. Heating, Ventilation and Air Conditioning System (HVAC)

During all operating hours the HVAC system serving the Premises, to be repaired and maintained by the LESSOR, shall be capable of maintaining the Premises at 78º Dry Bulb at a maximum range of 40% to 60% Relative humidity during the summer when the outdoor temperature is 95º Dry Bulb, and at 68º Dry Bulb in the winter when the outside temperature is 35º Dry Bulb.

In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142, and as it may be subsequently amended, LESSOR shall inspect the HVAC system at least once annually or on a schedule agreed to in writing by LESSOR and COUNTY, and provide repair and maintenance accordingly. LESSOR's inspections and maintenance of the HVAC system shall be documented in writing. The LESSOR shall at a minimum, maintain a record of: (a) the name of the individual(s) inspecting and/or maintaining the system, (b) the date of the inspection and/or maintenance, and (c) the specific findings and actions taken. The LESSOR shall ensure that such records are retained for at least five (5) years. The LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request from COUNTY. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any rent payable.

B. Janitorial Supplies and Services

LESSOR shall provide janitorial supplies and services on a five-day-per-week basis (Monday through Friday) to the common areas and common area restrooms in accordance with Exhibit D (JANITORIAL SPECIFICATIONS) attached hereto and by reference made a part hereof.

If LESSOR fails to provide satisfactory janitorial supplies to Premises, the Chief Real Estate Officer, or designee may notify LESSOR either verbally or in writing; and if LESSOR does not provide janitorial supplies within twenty-four (24) hours after LESSOR has received such written notice from COUNTY, COUNTY may provide the janitorial supplies necessary or have others do

so, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs and/or services the same day any emergency repairs and/or services are necessary to remedy the emergency condition, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary repairs within a reasonable time or provide the necessary services, as determined by the Chief Real Estate Officer, COUNTY may at its option have the necessary repairs made and/or provide services to remedy the emergency condition, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

10. ELECTRIC UTILITIES (5.2 N)

COUNTY shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the interior of the Premises directly to the utility company.

LESSOR shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the exterior of the Premises and to the common areas of the property in which the Premises is located.

INSURANCE (5.3 S)

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against COUNTY by the insurance company issuing said policy or policies. LESSOR shall provide COUNTY with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring

within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

a. Name COUNTY as an additional insured;
b. Shall be primary, and any insurance or self-insurance maintained by COUNTY shall be excess and non-contributing;
c. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
d. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence; and
e. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

11. INDEMNIFICATION (5.5 A S)

LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties.

12. TAXES AND ASSESSMENTS (5.6 N)

All taxes and assessments which become due and payable upon the Premises shall be the full responsibility of LESSOR, and LESSOR shall cause said taxes and assessments to be paid prior to the due date.

COUNTY shall reimburse LESSOR for its proportionate share of Taxes and Assessments pursuant to Section 5 of this Lease.

13. BUILDING AND SAFETY REQUIREMENTS (5.7 S)

During the full term of this Lease, LESSOR, at LESSOR's sole cost, agrees to maintain the Premises in compliance with all applicable laws, rules, regulations, building codes, statutes, and orders as they are applicable on the date of this Lease, and as they may be subsequently amended.

Included in this provision is compliance with the Americans with Disabilities Act ("**ADA**") and all other federal, state, and local codes, statutes, and orders relating to disabled access as they are applicable on the dates of this Lease, and as they may be subsequently amended.

LESSOR further agrees to maintain the Premises as a "safe place of employment," as defined in the California Occupational Safety and Health Act (California Labor Code, Division 5, Part 1, Chapter 3, beginning with Section 6400) and the Federal Occupational Safety and Health Act, where the provisions of such Act exceed, or supersede, the California Act, as the provisions of such Act are applicable on the date of this Lease, and as they may be subsequently amended.

In the event LESSOR neglects, fails, or refuses to maintain said Premises as aforesaid, COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, cure any such default by performance of any act, including payment of money, and subtract the cost thereof plus reasonable administrative costs from the rent.

14. TOXIC MATERIALS (5.9 S)

COUNTY hereby warrants and represents that COUNTY will comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "**Toxic Materials**"). COUNTY shall be responsible for and shall defend, indemnify and hold LESSOR, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the storage, use, and disposal of Toxic Materials on the Premises by COUNTY. If the storage, use, and disposal of Toxic Materials on the Premises by COUNTY results in contamination or

deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, COUNTY shall promptly take any and all action necessary to clean up such contamination.

Likewise, LESSOR hereby warrants and represents that LESSOR has in the past and will hereafter comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "Toxic Materials"). LESSOR shall be responsible for and shall defend, indemnify and hold COUNTY, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the previous, current and future storage, use and disposal of Toxic Materials on the Premises (or building if the Premises comprises only a portion of said building) by LESSOR. If the previous, current and future storage, use, and disposal of Toxic Materials on the Premises by LESSOR results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, LESSOR shall promptly take any and all action necessary to clean up such contamination.

15. SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE (6.4 S)

This Lease and all rights of the COUNTY hereunder are subject and subordinate to any mortgage or deed of trust which does now or may hereafter cover the Premises or any interest of LESSOR therein, and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions of any such mortgage or deed of trust; except, insofar as COUNTY is meeting its obligations under this Lease, any foreclosure of any mortgage or deed of trust shall not result in the termination of this Lease or the displacement of COUNTY.

In the event of transfer of title to the Premises, including any proceedings brought for foreclosure or in the event of the exercise of the power of sale under any mortgage or deed of trust or by any other transfer of title covering the Premises, COUNTY shall attorn to and recognize any subsequent title holder as the LESSOR under all terms, covenants and conditions of this Lease. COUNTY's possession of the Premises shall not be disturbed by the LESSOR or its successors in interest, and this Lease shall remain in full force and effect. Said attornment shall be effective and self-operative immediately upon succession of the current title holder, or its successors in interest, to the interest of LESSOR under this Lease.

Notwithstanding the above, this Lease is contingent upon LESSOR's obtaining a Subordination, Attornment and Non-Disturbance Agreement from LESSOR’s lender, within thirty (30) days of

LESSOR's execution of this Lease. LESSOR shall require all future lenders on the Premises upon initiation of their interest in the Premises, to enter into a Subordination, Attornment and Non-Disturbance Agreement with COUNTY thereby insuring COUNTY of its leasehold interests in the Premises. Said Subordination, Attornment and Non-Disturbance Agreement shall be in the form of COUNTY's standard form Subordination, Attornment and Non-Disturbance Agreement shown on Exhibit E, attached hereto and by reference made a part hereof, or in a form approved by the Chief Real Estate Officer, and County Counsel.

Foreclosure shall not extinguish this Lease, and any lender or any third party purchasing the Premises at foreclosure sale shall do so subject to this Lease and shall thereafter perform all obligations and be responsible for all liabilities of the LESSOR under the terms of this Lease.

Upon default by LESSOR of any note or deed of trust, COUNTY may, at its option, make all lease payments directly to the lender, and same shall be applied to the payment of any and all delinquent or future installments due under such note or deed of trust.

16. ESTOPPEL CERTIFICATE (6.5 S)

COUNTY agrees that the County Executive Officer shall furnish from time to time upon receipt of a written request from LESSOR or the holder of any deed of trust or mortgage covering the Premises or any interest of LESSOR therein, COUNTY's standard form Estoppel Certificate containing information as to the current status of the Lease. The Estoppel Certificate shall be approved by the Chief Real Estate Officer, and County Counsel.

17. DEFAULTS AND REMEDIES (6.8 S)

The occurrence of any of the following shall constitute an event of default:

- Failure to pay any installment of any monetary amount due and payable hereunder;
- Failure to perform any obligation, agreement or covenant under this Lease.

In the event of any non-monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any non-monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach and LESSOR shall have fifteen (15) days in which to initiate action to cure said

breach.

In the event of any monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

In the event of any monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach, and LESSOR shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

18. DEBT LIMIT (6.9 S)

LESSOR acknowledges and agrees that the obligation of the COUNTY to pay rent under this Lease is contingent upon the availability of COUNTY funds which are appropriated or allocated by the COUNTY's Board of Supervisors for the payment of rent hereunder. In this regard, in the event that this Lease is terminated due to an uncured default of the COUNTY hereunder, LESSOR may declare all rent payments to the end of COUNTY's current fiscal year to be due, including any delinquent rent from prior budget years. In no event shall LESSOR be entitled to a remedy of acceleration of the total rent payments due over the term of the Lease. The Parties acknowledge and agree that the limitations set forth above are required by Article 16, section 18, of the California Constitution. LESSOR acknowledges and agrees that said Article 16, section 18, of the California Constitution supersedes any law, rule, regulation or statute, which conflicts with the provisions of this paragraph. Notwithstanding the foregoing, LESSOR may have other rights or civil remedies to seek relief due to the COUNTY's default under the Lease. Such rights or remedies may include a right to continue the COUNTY's right of possession under the Lease and sue for the rent as it becomes past due.

19. LABOR CODE COMPLIANCE (6.10 S)

LESSOR acknowledges and agrees that all improvements or modifications required to be performed as a condition precedent to the commencement of the term of this Lease or any such future improvements or modifications performed by LESSOR at the request of COUNTY shall be governed by, and performed in accordance with, the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (Sections 1770, et seq.). These provisions are applicable to improvements or modifications costing more than $1,000.

Pursuant to the provisions of Section 1773 of the Labor Code of the State of California, the Orange County Board of Supervisors has obtained the general prevailing rate of per diem wages and the general prevailing

rate for holiday and overtime work in the locality applicable to this Lease for each craft, classification, or type of workman needed to execute the aforesaid improvements or modifications from the Director of the State Department of Industrial Relations. Copies of said prevailing wage rates may be obtained from the State of California, Department of Industrial Relations, or the County Executive Officer.

LESSOR hereby agrees to pay or cause its contractors and/or subcontractors to pay said prevailing wage rates at all times for all improvements or modifications to be completed for COUNTY within the premises, and LESSOR herein agrees that LESSOR shall post, or cause to be posted, a copy of the most current, applicable prevailing wage rates at the site where the improvements or modifications are performed.

Prior to commencement of any improvements or modifications, LESSOR shall provide the County Executive Officer with the applicable certified payroll records for all workers that will be assigned to the improvements or modifications. Said payroll records shall contain, but not be limited to, the complete name, address, telephone number, social security number, job classification, and prevailing wage rate for each worker. LESSOR shall provide, the County Executive Officer bi-weekly updated, certified payroll records for all workers that include, but not be limited to, the weekly hours worked, prevailing hourly wage rates, and total wages paid.

If LESSOR neglects, fails, or refuses to provide said payroll records to the County Executive Officer, such occurrence shall constitute an event of default of this lease and COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, COUNTY may deduct future rent payable to LESSOR by COUNTY as a penalty for such non-compliance of paying prevailing wage, which rent deduction would be COUNTY's estimate, in its sole discretion, or such prevailing wage rates not paid by LESSOR.

Except as expressly set forth in this Lease, nothing herein is intended to grant authority for LESSOR to perform improvements or modifications on space currently leased by COUNTY or for which COUNTY has entered into a lease or lease amendment.

20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S)

In order to comply with child support enforcement requirements of the County of Orange, within thirty (30) days after COUNTY's execution of this Lease agreement, LESSOR agrees to furnish the County Executive Officer, COUNTY's standard form, *Child Support Enforcement Certification Requirements*, which includes the following information:

A. In the case where LESSOR is doing business as an individual, LESSOR's name, date of birth, Social Security number, and residence address;

B. In the case where LESSOR is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

C. A certification that the LESSOR has fully complied with all applicable federal and state reporting requirements regarding its employees; and

D. A certification that the LESSOR has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.

Failure of LESSOR to timely submit the data and/or certifications required above or to comply with all federal and state reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Lease. Failure to cure such breach within sixty (60) calendar days of notice from the County Executive Officer shall constitute grounds for termination of this Lease.

Notwithstanding any other provisions of this Lease, LESSOR shall be given an opportunity to cure as follows:

A. A notice of any claimed failure to comply shall be given to LESSOR, in writing, by personal delivery, or facsimile transmission, from the County Executive Officer. The written notice shall state the specific data or certification required, the specific federal or state reporting requirements for child support enforcement that has not been complied with or the specific Wage and Earnings Assignment Order and Notice of Assignment that has not been complied with; and

B. LESSOR shall have sixty (60) days from the actual receipt of the written notice to cure the failure to comply specified in the notice, provided that LESSOR's performance to cure within sixty (60) days is not hindered, impaired or prevented by federal, state or local agencies. If the claimed failure as set forth in the written notice is failure to perform an act by a certain time, the failure of performance of said certain act by said certain time shall be deemed cured for purposes of this Lease if it is timely performed in accordance with the provisions of this paragraph.

It is expressly understood that this data will be transmitted to governmental agencies charged with the

establishment and enforcement of child support orders and will not be used for any other purpose.

21. RIGHT TO WORK AND MINIMUM WAGE LAWS (6.13 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LESSOR shall require its employees that directly or indirectly service the Premises or terms and conditions of this Lease, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LESSOR shall also require and verify that its contractors or any other persons servicing the Premises or terms and conditions of this Lease, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LESSOR shall pay no less than the greater of the Federal or California minimum wage to all its employees that directly or indirectly service the Premises, in any manner whatsoever. LESSOR shall require and verify that all its contractors or other persons servicing the Premises on behalf of the LESSOR also pay their employees no less than the greater of the Federal or California minimum wage.

LESSOR shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the Premises or terms and conditions of this Lease.

Notwithstanding the minimum wage requirements provided for in this clause, LESSOR, where applicable, shall comply with the prevailing wage and related requirements, as provided for in the Clause entitled LABOR CODE COMPLIANCE of this Lease.

22. AUTHORITY (N)

The Parties to this Lease represent and warrant that this Lease has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

23. NOTICES (8.1 S)

All written notices pursuant to this Lease shall be addressed as set forth below or as either party may hereafter designate by written notice and shall be deemed delivered upon personal delivery, delivery by facsimile machine, or seventy-two (72) hours after deposit in the United States Mail.

TO: LESSOR Charles H. Manh and Anh Manh Manh Family Trust 8990 Westminster Blvd., Second Floor Westminster, CA 92683	TO: COUNTY County of Orange 333 Santa Ana Blvd., 3rd Floor Santa Ana, CA 92701 Attention: Scott Mayer, Chief Real Estate Officer Email: Scott.Mayer@ocgov.com Phone: (714) 834-3046

24. ATTACHMENTS (8.2 S)

This Lease includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
   A. Description - Premises
   B. Plot Plan - Premises
   C. Performance Specifications
   D. Janitorial Specifications
   E. Subordination, Attornment, and Non-Disturbance Agreement

25. MISCELLANEOUS (N)

COUNTY may remove and dispose, and in a manner best suited for such removal and disposition, of any item(s) of furniture ("**Furniture Items**") off the Premises, which is (are) personal property of the LESSOR, as COUNTY deems appropriate or is of no use for COUNTY. LESSOR hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of property arising from, growing out of or in any way connected with or related to the removal and disposition of the Furniture Items except claims arising from the concurrent active negligence of COUNTY, its officers, agents, and employees.

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IN WITNESS WHEREOF, the parties have executed this Agreement the day and year first above written.

LESSOR

CHARLES H. MANH and ANH MANH,
Co-Trustees of the MANH FAMILY TRUST, dated August 15, 2006

By: _____ May 25th, 2016
CHARLES H. MANH, Co-Trustee

By: _____ May 25th, 2016
ANH MANH, Co-Trustee

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APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy County Counsel

COUNTY

COUNTY OF ORANGE
Chief Real Estate Officer

_____
By: Scott D. Mayer Per Ordinance No. 15-009 of the Board of Supervisors and Minute Order dated June 9, 2015

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GENERAL CONDITIONS (9.1-9.17 S)

1. LEASE ORGANIZATION (9.1 S)

The various headings in this Lease, the numbers thereof, and the organization of the Lease into separate sections and paragraphs are for purposes of convenience only and shall not be considered otherwise.

2. INSPECTION (9.2 N)

LESSOR or his authorized representative shall have the right at all reasonable times and upon reasonable advance notice to COUNTY, which authorization shall not be unreasonably withheld, to inspect the Premises to determine, if COUNTY is complying with all the provisions of this Lease.

3. SUCCESSORS IN INTEREST (9.3 S)

Unless otherwise provided in this Lease, the terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators, and assigns of all the parties hereto, all of whom shall be jointly and severally liable hereunder.

4. DESTRUCTION OF OR DAMAGE TO PREMISES (9.4 S)

"Partial Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is less than 25% of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

"Total Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is 25% or more of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

In the event of a Partial Destruction of the Premises, LESSOR shall immediately pursue completion of all repairs necessary to restore the Premises to the condition which existed immediately prior to said Partial Destruction. Said restoration work (including any demolition required) shall be completed by LESSOR, at LESSOR's sole cost, within sixty (60) days of the occurrence of said Partial Destruction or within an extended time frame as may be authorized, in writing, by COUNTY. The Partial Destruction of the Premises shall in no way render this Lease and/or any option to purchase null and void; however, rent payable by COUNTY under the Lease shall be abated in proportion to the extent COUNTY's use and occupancy of the Premises is adversely affected by said Partial Destruction, demolition, or repair work

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required thereby. Should LESSOR fail to complete necessary repairs, for any reason, within sixty (60) days, or other time frame as may be authorized by COUNTY, COUNTY may, at COUNTY's sole option, terminate the Lease or complete necessary repair work and deduct the cost thereof, including labor, materials, and overhead from any rent thereafter payable.

In the event of Total Destruction of the Premises or the Premises being legally declared unsafe or unfit for occupancy, this Lease and/or any option shall in no way be rendered null and void and LESSOR shall immediately instigate action to rebuild or make repairs, as necessary, to restore the Premises (including replacement of all tenant improvements) to the condition which existed immediately prior to the destruction. All rent payable by COUNTY shall be abated until complete restoration of the Premises is accepted by COUNTY. In the event LESSOR refuses to diligently pursue or is unable to restore the Premises to an occupiable condition (including replacement of all tenant improvements) within 180 days of the occurrence of said destruction or within an extended time frame as may be authorized, in writing, by COUNTY, COUNTY may, at COUNTY's sole option, terminate this Lease or complete the restoration and deduct the entire cost thereof, including labor, materials, and overhead from any rent payable thereafter.

Further, LESSOR, at COUNTY's request, shall provide a suitable, COUNTY-approved temporary facility ("**Facility**") for COUNTY's use during the restoration period for the Premises. The Facility may be leased, at market rate, under a short term lease, for which the COUNTY will reimburse LESSOR the cost thereof, on a monthly basis.

5. AMENDMENT (9.5 S)

This Lease sets forth the entire agreement between LESSOR and COUNTY and any modification must be in the form of a written amendment.

6. PARTIAL INVALIDITY (9.6 S)

If any term, covenant, condition, or provision of this Lease is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

7. CIRCUMSTANCES WHICH EXCUSE PERFORMANCE (9.7 S)

If either Party hereto shall be delayed or prevented from the performance of any act required hereunder by reason of acts of God, performance of such act shall be excused for the period of the delay; and the period for the performance of any such act shall be extended for a period equivalent to the period of such

delay. Financial inability shall not be considered a circumstance excusing performance under this Lease.

8. WAIVER OF RIGHTS (9.9 S)

The failure of LESSOR or COUNTY to insist upon strict performance of any of the terms, conditions, and covenants in this Lease shall not be deemed a waiver of any right or remedy that LESSOR or COUNTY may have, and shall not be deemed a waiver of any right or remedy for a subsequent breach or default of the terms, conditions, and covenants herein contained.

9. HOLDING OVER (9.10 S)

In the event COUNTY shall continue in possession of the Premises after the term of this Lease, such possession shall not be considered a renewal of this Lease but a tenancy from month to month and shall be governed by the conditions and covenants contained in this Lease.

10. HAZARDOUS MATERIALS (9.11 S)

LESSOR warrants that the Premises is free and clear of all hazardous materials or substances.

11. EARTHQUAKE SAFETY (9.12 N)

LESSOR is informed and believes that the Premises is not in violation of any applicable seismic safety regulations and building codes.

12. QUIET ENJOYMENT (9.13 S)

LESSOR agrees that, subject to the terms, covenants and conditions of this Lease, COUNTY may, upon observing and complying with all terms, covenants and conditions of this Lease, peaceably and quietly occupy the Premises.

13. WAIVER OF JURY TRIAL (9.15 S)

Each Party acknowledges that it is aware of and has had the advice of Counsel of its choice with respect to its rights to trial by jury, and each party, for itself and its successors and assigns, does hereby expressly and knowingly waive and release all such rights to trial by jury in any action, proceeding or counterclaim brought by any party hereto against the other (and/or against its officers, directors, employees, agents, or subsidiary or affiliated entities) on or with regard to any matters whatsoever arising out of or in any way

connected with this agreement and/or any claim of injury or damage.

14. GOVERNING LAW AND VENUE. (9.16 S)

This agreement has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this agreement, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394.

15. TIME (9.17 S)

Time is of the essence of this Lease.

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EXHIBIT A

DESCRIPTION OF PREMISES (10.1 N)

PROJECT: Community Customer Service Annex

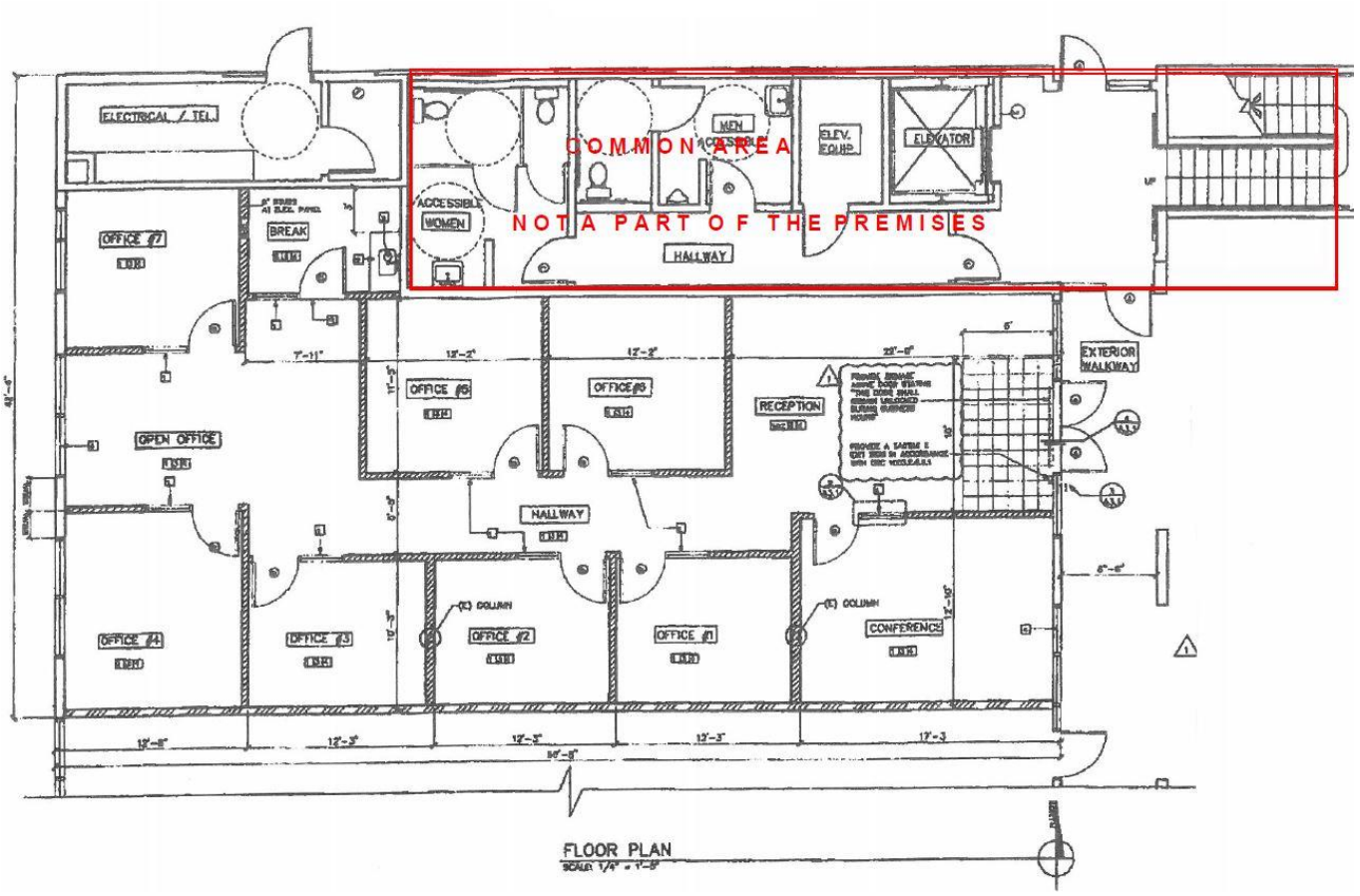
All the Premises shown as the floor plan marked Exhibit B, attached hereto and made a part hereof, being a portion of the first floor of that certain two (2) story building located at 15496 Magnolia Street, Suite 111, in the City of Westminster, County of Orange, State of California, together with non-exclusive use of common area restrooms and thirteen (13) parking spaces in the parking areas shown on Exhibit B.

NOT TO BE RECORDED

EXHIBIT B

FLOOR PLAN OF PREMISES

15496 MAGNOLIA STREET, SUITE 111,
WESTMINSTER, CA



Gross Leasable Area: 2,120 Square Feet

EXHIBIT C

PERFORMANCE SPECIFICATIONS (10.3N) LESSOR shall perform the following Work prior to the Commencement Date of this Lease and according to the Tenant Improvement Performance Specifications that follow:

Specific locations to be identified by COUNTY prior to lease execution

1. Repair or replace door closer.
2. Replace stained ceiling tiles.
3. Repair or replace door closer.
4. Remove any signage from previous tenant that exists inside or outside of the Premises
5. Re-key front door and any internal door locks.
6. Provide the security code for existing alarm system.
7. Deliver the Premises with all electrical, plumbing and HVAC systems in proper working order.
8. Repair or replace any HVAC components resulting from findings of COUNTY's inspection of the HVAC system.

1. HEAT, VENT & AIR CONDITION ("HVAC")

A. Heating & air conditioning equipment shall have the capability of maintaining all occupied indoor areas at the room temperatures shown when outdoor temperatures are as follows:

OUTDOORS	*MAINTAIN INDOORS*
Summer – 95° Dry Bulb	78° Dry Bulb at a maximum range of 40% to 60% Relative humidity
Winter – 35° Dry Bulb	68° Dry Bulb

B. All HVAC controls pertinent to the Premises are to be located within the Premises.

C. All HVAC thermostats shall be concealed by a clear plastic tamper proof lock box.

2. ELECTRICAL & COMMUNICATIONS

A. Provide and install fluorescent lighting at all interior spaces that meet code and provide the following minimum lighting intensities at desk level:

LOCATION	*MINIMUM FOOT CANDLES:*
General Offices/Utility Rooms	60
Public Areas	30
General Corridors	20
LOCATION	*MINIMUM FOOT CANDLES:*
Other interior areas	I.E.S. Recommended Levels
Parking Lot	1

B. All Lighting controls pertinent to the Premises shall be located within the Premises.

COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT ("ADA")

LESSOR shall assure that the Premises and Property are in compliance with current standards of the Americans with Disabilities Act for ingress and egress to the Premises and Property.

EXHIBIT D

JANITORIALSPECIFICATIONS (10.4 N)

It is the intent of this Exhibit to provide general guidelines for minimum janitorial service. Any absence of a specific janitorial service from this Exhibit does not relieve LESSOR of the obligation to provide such service should it become necessary.

Janitorial service as required in the clause entitled (REPAIR, MAINTENANCE AND JANITORIAL SERVICE) of this Lease, shall be inclusive of, but not limited to, the services as detailed below:

RESTROOMS

A. **NIGHTLY**:

1. Clean and damp-mop floors;
2. Wash all mirrors, bright work and enameled surfaces;
3. Wash and sanitize all basins, bowls, urinals, and toilet seats;
4. Dust, clean, and wash where necessary, all partitions, tile walls, dispensers, and receptacles;
5. Empty and sanitize all receptacles and sanitary napkin disposals;
6. Provide materials and fill all toilet tissue, towel, seat cover, sanitary napkin, and soap dispensers.

B. **MONTHLY**:

1. Machine strip restroom floors and apply finish/sealer where applicable;
2. Wash all partitions, tile walls, and enamel surfaces;
3. Vacuum all louvers, vents, and dust light fixtures.

MISCELLANEOUS SERVICES

1. Maintain building common/shared areas, corridors, and other public areas in a clean condition;
2. Surface parking lot is to be cleaned on a monthly or more frequent basis;
3. All interior and exterior windows of the building are to be cleaned quarterly.

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EXHIBIT E

SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT

THIS IS A SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT, made _____, 20__, by and between the County of Orange ("COUNTY") and _____ ("LENDER").

A. By lease dated _____, ("Lease"), _____ ("LESSOR") leased to COUNTY and COUNTY leased from LESSOR those certain Premises described as: _____.

B. LENDER is the holder or about to become the holder of a mortgage or Deed of Trust ("Note") which constitutes or will constitute a lien against the Premises leased by COUNTY pursuant to the aforesaid Lease.

C. LENDER has requested that _____ execute a Subordination, Attornment and Non-Disturbance Agreement in accordance with the terms of the Lease.

NOW, THEREFORE, the parties hereto do hereby agree as follows:

1. Subject to the terms and conditions of the Lease, all rights of COUNTY thereunder are or shall become subordinate to the Note and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions thereof.

2. In the event that LENDER succeeds to the interest of LESSOR under the Lease, by reason of foreclosure of the Note, by other proceedings brought to enforce any rights of LENDER under the Note, by deed in lieu of foreclosure, or by any other method, COUNTY shall promptly attorn to LENDER under all of the terms, covenants, and conditions of the Lease for the balance of the then-current term (and any extension or renewals thereof which may be effective in accordance with any option therefore contained in the Lease), with the same force and effect as if LENDER were the Lessor under the Lease. So long as COUNTY is not in default under the Lease, LENDER or its successors in interest shall not disturb the interests of COUNTY under said Lease, but shall allow said interests to continue in full force and effect for the balance of the then-current term and any extension available to COUNTY which may be provided in accordance with the Lease. Said attornment shall be effective and self-operative immediately upon LENDER'S succession to the interest of LESSOR under the Lease.

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3. This agreement may not be modified orally or in any manner other than by written agreement signed by the parties hereto or their respective successors or assigns. All of the terms, covenants, and conditions herein shall run with the land and shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

COUNTY:

COUNTY OF ORANGE

By:_____

County Chief Real Estate Officer

LENDER:

By:_____

Print Name:_____

Title:_____

APPROVAL AS TO FORM:
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By:_____

Deputy County Counsel

Date:_____

H.L. MILLER incorporated

A General Construction Company

PROPOSAL

Date	Proposal #
7/27/2016	3827

Name / Address
SOCIAL SERVICES AGENCY 500 N. State College Blvd. Orange, CA 92868 ATTN: AL PASILLAS E: Al.Pasillas@ssa.ocgov.com

Description	Total
JOB SITE: 15946 Magnolia, Suite 111 - Wall Removal REF: MA-063-16011114	
1. Remove 18' x 9' of wall with one window and one door and haul away. 2. Finish corner and replace any ceiling tiles damaged from the wall removal. Remove switches in conference room and tie lighting in both rooms to one set of switches. CARPENTER: 17 Hours at $85/Hr = $1,445.00 DRYWALL: 6 Hours at $90/Hr = $540.00 PAINTING: 4 Hours at $80/Hr = $320.00 ELECTRICAL: 9 Hours at $75/Hr = $675.00 ELECTRICAL HELPER: 9 Hours at $50/Hr = $450.00 ESTIMATED MATERIAL: $350.00 + 10% = $385.00	3,815.00
3. Remove carpet in both rooms and haul away. Prep floor and install 65.5 Sq. Yds. of level loop light to medium beige carpet. FLOORING: 18 Hours at $61/Hr - $1,098.00 ESTIMATED MATERIAL: $1,902.41 + 10% = $2,091.55	3,189.55
4. Repair carpet with similar color where wall was removed. (4" x 15'). FLOORING: 6 Hours at $61/Hr = $366.00 ESTIMATED MATERIAL: $250.00 + 10% = $275.00	641.00
Howard L. Miller, President JA QUOTE IS GOOD FOR 60 DAYS.	

Please make checks payable to:H.L. Miller, Inc. CA State Contractors Lic. #385912 Tax ID 56-2399764	**Total** $7,645.55

PURSUANT TO CALIFORNIA PUBLIC CONTRACT CODE, SECTION 20104.50, INTEREST IS DUE IF NOT PAID WITHIN 30 DAYS OF THE ABOVE DATE, AT THE RATE ALLOWED IN THE CODE OF CIVIL PROCEDURE SECTION 685.101.

2201 E. Winston Road, Unit I, Anaheim, CA 92806-5537
Phone: (714) 998-8699 • Fax: (714) 998-8698 • Email: hlmcinc@aol.com

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

34. Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Service Center

Contact

Phil Tsunoda, Executive Director Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to negotiate an Amendment to the License Agreement compliant with CalOptima's obligations under applicable state and federal laws regarding the privacy of CalOptima members and their protected health information and extend the License Agreement with the County of Orange for up to an additional four years through June 30, 2021, which allows use of approximately 362 square feet of space at the County Community Service Center (CCSC), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683;
2. Approve allocation of $18,831.76, which has been included in CalOptima's proposed Fiscal Year (FY) 2017-2018 Operating Budget to fund the extension of the License Agreement; and .
3. Authorize staff expenditures of $66,230 in FY 2017-18, plus equipment for a full time Customer Service Representative (CSR) at the licensed site.

Background

As a public agency and community health plan that serves the low-income Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging our members in efforts with our community-based organizations, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Since 2008, CalOptima utilized space at the main CCSC office at no cost to CalOptima to offer monthly education seminars to increase our members' knowledge about CalOptima's programs and services and information to support our members' health care needs. Due to CalOptima's growth in membership and programs and increased interest in the health education seminars, the space at the main office limited the number of members served at the main CCSC office.

In May 2016, Orange County Social Services Agency informed CalOptima of an opportunity to expand our capacity at the CCSC by licensing space located across the parking lot from the main CCSC office. The licensed space provides one dedicated office and access to a shared conference room 50 percent of the time. On August 4, 2016, CalOptima's Board of Directors authorized the CEO to enter into a one-year license agreement with the County of Orange for usage of the space at the CCSC at a cost of approximately $23,000 for removal of a wall and licensing fees through June 30, 2017.

Since September 2016, CalOptima staff has been on-site to provide information and education about CalOptima's programs and services, enhanced customer service support, and additional monthly

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educational seminars. The satellite office is centrally-located in the county and may be more convenient for certain CalOptima members who reside in the cities of Santa Ana, Garden Grove and Westminster. While visitation has been limited to an average of less than two members per day to date, staff is hopeful that a greater number of members will be receiving information at the site in the future.

Since the CCSC grand opening in September 2016, staff from various CalOptima departments have been on-site to serve members including Behavioral Health Integration, Program of All-Inclusive Care (PACE), OneCare Connect Sales and Marketing, Customer Service and Community Relations Departments. Services offered on-site include information and referrals for our programs and services, information and enrollment in the PACE and OneCare Connect programs, assistance with navigating health care benefits, educational seminars and customer service related issues including provider and health network selection, referrals, and requesting replacementID cards.

Since the opening of the new CCSC site, CalOptima has increased the health education seminars from one Vietnamese health education seminar to three seminars per month to include English and Spanish seminars, expanding our reach to English and Spanish-speaking members. CalOptima collaborated with community-based organization and internal departments to provide 21 educational seminars over the past nine months, or roughly three events per month, at the CCSC site. Topics presented include:

- The Importance of Vaccinations
- Understanding Social Security Programs and Benefits
- Dementia: The Basics: What it is and is not?
- Who is CalOptima? Understanding Your Medi-Cal Benefits
- Good Oral Care: Understanding Your Denti-Cal Benefits and Accessing Dental Services
- Mental Health Wellness: Understanding and Accessing Behavioral Health Benefits and Services

In January 2017, CalOptima started offering New Member Orientations for our Vietnamese-speaking members at the satellite office. A total of six New Member Orientations were conducted for our Medicare/Medi-Cal members and new Medi-Cal members.

Over 350 members have been provided with information and health education at the licensed site through the activities listed above in the nine months since the site's opening in September 2016. Foot traffic has averaged one to two members daily, and staff is hopeful that more members will receive information from the location with increased awareness of the licensed site and additional outreach efforts to members, providers and community-based organizations.

In addition to CalOptima's services, the CCSC offers a variety of health and human services to local residents including resources and referrals, application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from Health Care Agency, Housing Authority, Family Caregiver Resource Center, and Office on Aging and Council on Aging are available to assist members on designated days.

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CalOptima's primary challenge at the licensed site has been the lack of full-time staff available to serve our members on-site. While staff has made many efforts to provide full-time coverage by developing shifts for various departments, we still received feedback from members about the importance of having a full-time Customer Service Representative on-site. Staff has addressed this concern by budgeting for an additional full-time, bi-lingual Customer Service Representative who will begin duties at the CCSC in late May 2017.

To increase awareness of the licensed site in the community, CalOptima is implementing a number of outreach strategies to members, internal departments, health networks, providers and community-based organizations to increase utilization of services available. Activities include mailers to members residing in a two-mile radius of the satellite office, communications to health networks and providers through CalOptima's newsletters and weekly communications, and targeted site visits to providers, health clinics and community-based organizations within a two-mile radius.

Discussion

Staff recommends authorization to negotiate an amendment to the License Agreement to ensure compliance with applicable state and federal privacy laws and to extend the License Agreement with the County of Orange. The licensed site establishes a presence in the community and is available to provide information to members regarding benefits and health education to support their health care needs.

The current License Agreement allows for one dedicated office, shared use of a conference room and use of the common area. The total leased space for the CCSC is comprised of 2,080 square feet with CalOptima's use of 109 square feet for the dedicated office, 253 square feet for the shared conference room, and estimated 21 percent use of the common area. The License Agreement was approved by CalOptima's Board of Directors on August 4, 2016 for the license period of August 5, 2016 through June 30, 2017.

The proposed extension of the License Agreement for the CCSC would include an increase in the license term for an additional four years through June 30, 2021, increase in the monthly license fee from $1,453.02 per month to $1,560.98 per month for the months of July 1, 2017 through June 30, 2021, and the addition of a new standard insurance clause requiring CalOptima to meet all County insurance's requirements. CalOptima would also negotiate additional amendments as necessary to ensure compliance with applicable state and federal privacy requirements.

The Director of Financial Compliance reviewed the insurance requirements in the Amendment with CalOptima's broker and confirmed that CalOptima can meet these requirements; as proposed, this location can be added to CalOptima's General Liability policy at an additional annual premium of no more than $100.

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	Total Amount
License Fee (July 2017 - June 2018) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$18,731.76
Standard Insurance	$100.00
Computer and telecommunications equipment	$5,000.00
Full time bilingual customer service representative	$66,230.00
Total	$90,061.76

As proposed, the amended License Agreement would take effect on July 1, 2017, contingent on successful negotiations with the County and the agreement being fully executed and approved by the County of Orange's Board of Supervisors. The contract allows CalOptima to cancel the contract with 30-day's notice at any time.

The County of Orange's proposed extension to the License Agreement is for up to four additional years for the period of July 1, 2017 through June 30, 2021. Staff is proposing approval of the License Agreement for this period.

Fiscal Impact
The fiscal impact to execute a license agreement amendment to extend the term of the contract with the County of Orange for the period of July 2, 2017 through June 30, 2021, is approximately $75,000. Of this amount, $18,831.76 is budgeted under the proposed CalOptima FY 2017-18 Operating Budget pending Board approval for the period of July 1, 2017 through June 30, 2018. In addition, the annual cost of placing a full time bilingual customer service representative at the site is projected to total $66,230 in FY2017-18, plus $5,000 for computer/telework equipment for a total of $90,061.76 for FY 2017-18.

Rationale for Recommendation
As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a licensed site in central Orange County, CalOptima is able to expand services to our members and build a presence in the community. The satellite office provides CalOptima with an opportunity to expand services to its members and provide direct support, increasing their ability to access health care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Fully Executed County of Orange License Agreement-Original
2. CCSC Cost Apply

/s/ Michael Schrader — *5/25/2017*
Authorized Signature — **Date**

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LICENSE AGREEMENT

This LICENSE AGREEMENT (**"License"**) is made and entered into August 4, 2016 (**"Effective Date"**), by and between, CALOPTIMA, (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property"**) pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The Services provided by LICENSEE will include a convenient on-site source while SSA clients are at the SSA Office.

III. COUNTY agrees to provide LICENSEE sufficient office space within the SSA Office for LICENSEE to provide the Services.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, COUNTY and LICENSEE do hereby agree as follows:

1. DEFINITIONS (AMLC-2.1 S)

The following words in this License have the significance attached to them in this clause, unless otherwise apparent from context:

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"Chief Real Estate Officer" means the Chief Real Estate Officer, County Executive Office, County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"**Facilities Services Manager**" means the Manager of the Social Services Agency, Facilities Services, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Director of Social Services Agency.

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"Risk Manager" means the Manager of County Executive Office, Risk Management, for the County of Orange, or upon written notice to LICENSEE, such entity as shall be designated by the County Executive Officer.

"SSA Director" means the Director of Social Services Agency, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. TERM (AMLC-3.1 N)

The term of this License shall commence on the Effective Date and terminate on June 30, 2017, unless terminated as provided in Clause 3 (TERMINATION) of this License.

3. TERMINATION (AMLC-3.3 S)

This License shall be revocable by either COUNTY's SSA Director or LICENSEE at any time; however, as a courtesy the Parties will attempt to give thirty (30) days written notice to the other Party upon revocation.

4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the non-exclusive right to use that certain property hereinafter referred to as **"License Area,"** shown on Exhibit A, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of the License Area will be determined by the Facilities Services Manager, and the location of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

5. PARKING (AMLC-4.4 S)

Throughout the term of this License COUNTY shall provide one (1) parking space for LICENSEE's free and non-exclusive use.

6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their Medi-Cal benefits.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

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NO ALCOHOLIC BEVERAGES OR TOBACCO PRODUCTS SHALL BE SOLD OR CONSUMED WITHIN THE LICENSE AREA.

7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the effective date of this License according to the following schedule:

MONTH	MONTHLY LICENSE FEE
1	$0.00
2	$361.73
3	$1,453.02
4	$1,453.02
5	$1,453.02
6	$1,453.02
7	$1,453.02
8	$1,453.02
9	$1,453.02
10	$1,453.02
11	$1,453.02
12	$1,453.02

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month. The fee for any partial calendar month during which this License becomes effective will be payable on such effective date.

8. PAYMENT PROCEDURE (AMLC-7.1 N)

All payments shall be delivered to the County of Orange, Office of the Auditor-Controller, P. O. Box 567 (630 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any time by COUNTY upon ten (10) days written notice to LICENSEE. License Fee payments may be made by check payable to the County of Orange. Said License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee for office space at the Orange County Community Service Center Annex in Westminster, California. A duplicate copy of the payment voucher shall be mailed to the County of Orange, Social Services Agency, 500 N. State College Boulevard, Orange, California,

92868, Attention: Facilities Services Manager. LICENSEE assumes all risk of loss if payments are made by mail.

No payment by LICENSEE or receipt by COUNTY of a lesser amount than the payment due shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction, and COUNTY shall accept such check or payment without prejudice to COUNTY's right to recover the balance of said payment or pursue any other remedy in this License.

9. CHARGE FOR LATE PAYMENT (AMLC-7.2 S)

LICENSEE hereby acknowledges that late payment of sums due hereunder will cause COUNTY to incur costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include but are not limited to costs such as administrative processing of delinquent notices, increased accounting costs, etc.

Accordingly, if any payment pursuant to this license is not received by COUNTY by the due date, a late charge of one and one-half percent (1.5%) of the payment due and unpaid plus $100 shall be added to the payment, and the total sum shall become immediately due and payable to the COUNTY. An additional charge of one and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

LICENSEE and COUNTY hereby agree that such late charges represent a fair and reasonable estimate of the costs that COUNTY will incur by reason of LICENSEE's late payment.

Acceptance of such late charges (and/or any portion of the overdue payment) by COUNTY shall in no event constitute a waiver of LICENSEE's default with respect to such overdue payment, or prevent COUNTY from exercising any of the other rights and remedies granted hereunder.

10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas and sewer),. County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). COUNTY shall be responsible for telephone service, internet service and janitorial service. All charges for services provided by COUNTY pursuant to this Clause shall be included in LICENSEE's "MONTHLY LICENSE FEE" pursuant to Clause 7. (LICENSE FEE) of the License.

11. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (AMD2.1 S)

COUNTY's Consent. No structures, improvements, or facilities shall be constructed, erected, altered, or made by LICENSEE within the License Area without prior written consent of the Facilities Services Manager. Any conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the Facilities Services Manager as a condition to granting such consent, shall be conditions hereof as though originally stated herein. LICENSEE may, at any time and at its sole expense, install and place business fixtures and equipment within License Area.

Strict Compliance with Plans and Specifications. All improvements constructed by LICENSEE within the

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License Area shall be constructed in strict compliance with detailed plans and specifications approved by the Facilities Services Manager.

COUNTY shall contract with a licensed contractor to remove the existing wall between the "Reception Area" and "Room #1" as depicted in Exhibit B, to replace existing carpet, and repair any areas resulting from removing said wall. LICENSEE shall reimburse COUNTY in the amount not to exceed Seven Thousand six hundred forty-five dollars and fifty-five cents ($7,645.55) within twenty (20) business days of COUNTY's submittal to LICENSEE of an invoice from COUNTY.

12. MECHANICS LIENS OR STOP-NOTICES (AMD4.1 S)

LICENSEE shall at all times indemnify, defend with counsel approved in writing by COUNTY and save COUNTY harmless from all claims, losses, demands, damages, cost, expenses, or liability costs for labor or materials in connection with construction, repair, alteration, or installation of structures, improvements, equipment, or facilities within the License Area, and from the cost of defending against such claims, including attorney fees and costs.

In the event a lien or stop-notice is imposed upon the License Area as a result of such construction, repair, alteration, or installation, LICENSEE shall either:

A. Record a valid Release of Lien, or

B. Procure and record a bond in accordance with Section 3143 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

Should LICENSEE fail to accomplish either of the two optional actions above within fifteen (15) days after the filing of such a lien or stop-notice, the License shall be in default and shall be subject to immediate termination.

13. OWNERSHIP OF IMPROVEMENTS (AMD6.1 N)

All improvements, exclusive of trade fixtures, constructed or placed within the License Area by LICENSEE must, upon completion, be free and clear all liens, claims, or liability for labor or material and at COUNTY's option shall be the property of COUNTY's at the expiration of this License or upon earlier termination hereof. COUNTY retains the right to require LICENSEE, at LICENSEE's cost, to remove all LICENSEE's improvements located on the License Area at the expiration or termination hereof.

14. INSURANCE (AML10.1 N)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with COUNTY during the entire term of this License. This License shall automatically terminate at the same time LICENSEE's insurance coverage is terminated. If within ten (10) business days after termination under this Clause LICENSEE obtains and provides evidence of the required insurance coverage acceptable to Facilities Services Manager, this License may be reinstated at the sole discretion of Facilities Services Manager.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Services Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Services Manager will only accept valid certificates of insurance and

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endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Services Manager reinstates the License.

If LICENSEE fails to provide Facilities Services Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Services Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by COUNTY from LICENSEE under this License. It is the obligation of LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.
All self-insured retentions (**"SIRs"**) and deductibles shall be clearly stated on the Certificate of Insurance. If no SIRs or deductibles apply, indicate this on the Certificate of Insurance with a "0" by the appropriate line of coverage. Any **SIR** or deductible in excess of $25,000 ($5,000 for automobile liability), shall specifically be approved by COUNTY's Risk Manager.

If LICENSEE fails to maintain insurance acceptable to COUNTY for the full term of this License, COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer licensed to do business in the state of California (California Admitted Carrier) or have a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category) as determined by the most current edition of the **Best's key Rating Guide/Property-Casualty/United States or ambest.com**.

If the insurance carrier is not an admitted carrier in the state of California and does not have an A.M. Best rating of A-/VIII, COUNTY's Risk Manager retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits

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Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (**"ISO"**) form CG 00 01, or a substitute form providing liability coverage at least as broad.
The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The following endorsements must be submitted with the Certificate of Insurance:

a) The Commercial General Liability policy shall contain an Additional Insured endorsement using ISO form CG 2010 or CG 2033 or a form at least as broad naming the COUNTY, its elected and appointed officials, officers, employees, and agents as Additional Insureds.

b) The Commercial General Liability policy shall contain a primary non-contributing endorsement evidencing that the LESSEE's insurance is primary and any insurance or self-insurance maintained by the COUNTY shall be excess and non-contributing.

c) The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the COUNTY, and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees.

d) The Commercial Property policy shall contain a Loss Payee endorsement naming the COUNTY as respects the COUNTY's financial interest when applicable.

All insurance policies required by this contract shall waive all rights of subrogation against the COUNTY and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

All insurance policies required by this contract shall give COUNTY thirty (30) days notice in the event of cancellation and ten (10) days for non-payment of premium. This shall be evidenced by policy provisions or an endorsement separate from the Certificate of Insurance.

The Commercial General Liability policy shall contain a severability of interests' clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to COUNTY's address provided in Clause 17 (NOTICES) below or to an address provided by SSA/Facilities Services Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by COUNTY's Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

15. OPERATIONS (AMLC-11.1 N)

LICENSEE shall keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair. COUNTY will, on LICENSEE's behalf, provide all maintenance and repairs to the License Area during the term of the License. LICENSEE is required to notify COUNTY of any and all necessary maintenance and repairs to the License Area on a timely basis.

LICENSEE expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary condition, to the complete satisfaction of COUNTY and in compliance with all applicable laws. LICENSEE further agrees to keep the License Area free and clear of rubbish and litter. COUNTY shall have the right to enter upon and inspect the License Area at any time for cleanliness and safety.

LICENSEE shall designate in writing to COUNTY an on-site representative who shall be responsible for the day to day operation and level of maintenance, cleanliness, and general order.

16. LIMITATION OF THE LICENSE (AMLC-13.1 S)

This License and the rights and privileges granted LICENSEE in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to LICENSEE of rights in the License Area, which exceed those owned by COUNTY.

17. HIPAA NOTICE (N)

LICENSEE acknowledges that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires COUNTY to safeguard and maintain the confidentiality of any Protected Health Information (PHI). LICENSEE hereby agrees not to access, remove, destroy, or relocate any property used by COUNTY to safeguard and store PHI. LICENSEE further agrees to use appropriate safeguards and to

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take all reasonable steps to prevent access to any PHI stored on the premises, including informing its workforce, contractors and vendors of the confidential nature of the records maintained by COUNTY. LICENSEE agrees to report to COUNTY within ten (10) calendar days any unauthorized use or any disclosure of PHI, which LICENSEE becomes aware. Upon COUNTY's knowledge of any breach, disclosure, or unauthorized use of PHI by LICENSEE, COUNTY shall:

a. Provide an opportunity for LICENSEE to cure the breach or end the violation. If LICENSEE does not cure the breach or end the violation within thirty (30) days or shorter period as required by COUNTY, COUNTY shall terminate this Agreement; or

b. Immediately terminate this Agreement if cure is not possible.

18. HAZARDOUS MATERIALS (AMLC-16.1 S)

A. Definition of Hazardous Materials. For purposes of this License, the term **"Hazardous Material"** or "Hazardous Materials" shall mean any hazardous or toxic substance, material, product, byproduct, or waste which is or shall become regulated by any governmental entity, including, without limitation, the COUNTY acting in its governmental capacity, the State of California or the United States government.

B. Use of Hazardous Materials. LICENSEE or LICENSEE's employees, agents, independent contractors or invitees (collectively **"LICENSEE Parties"**) shall not cause or permit any Hazardous Materials to be brought upon, stored, kept, used, generated, released into the environment or disposed of on, under, from or about the License Area (which for purposes of this clause shall include the subsurface soil and ground water). Notwithstanding the foregoing, LICENSEE may keep on or about the License Area small quantities of Hazardous Materials that are used in the ordinary, customary and lawful cleaning of and business operations on the License Area.

C. LICENSEE Obligations. If the presence of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties results in (i) injury to any person, (ii) injury to or contamination of the License Area (or a portion thereof), or (iii) injury to or contamination or any real or personal property wherever situated, LICENSEE, at its sole cost and expense, shall promptly take all actions necessary or appropriate to return the License Area to the condition existing prior to the introduction of such Hazardous Materials to the License Area and to remedy or repair any such injury or contamination. Without limiting any other rights or remedies of COUNTY under this License, LICENSEE shall pay the cost of any cleanup or remedial work performed on, under or about the License Area as required by this License or by applicable laws in connection with the removal, disposal, neutralization or other treatment of such Hazardous Materials caused or permitted by LICENSEE or LICENSEE Parties. Notwithstanding the foregoing, LICENSEE shall not take any remedial action in response to the presence, discharge or release, of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties, or enter into any settlement agreement, consent decree or other compromise with any governmental or quasigovernmental entity without first obtaining the prior written consent of the COUNTY. All work performed or caused to be performed by LICENSEE as provided for above shall be done in good and workmanlike manner and in compliance with plans, specifications, permits and other requirements for such work approved by COUNTY.

D. Indemnification for Hazardous Materials. To the fullest extent permitted by law, LICENSEE hereby agrees to indemnify, hold harmless, protect and defend (with attorneys acceptable to COUNTY) COUNTY, its elected officials, officers, employees, agents and independent contractors and the

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License Area, from and against any and all liabilities, losses, damages (including, but not limited, damages for the loss or restriction on use of rentable or usable space or any amenity of the License Area or damages arising from any adverse impact on marketing of the License Area), diminution in the value of the License Area, judgments, fines, demands, claims, recoveries, deficiencies, costs and expenses (including, but not limited to, reasonable attorneys' fees, disbursements and court costs and all other professional or consultant's expenses), whether foreseeable or unforeseeable, arising directly or indirectly out of the presence, use, generation, storage, treatment, on or off-site disposal or transportation of Hazardous Materials on, into, from, under or about the License Area by LICENSEE or LICENSEE's Parties. The foregoing indemnity shall also specifically include the cost of any required or necessary repair, restoration, clean-up or detoxification of the License Area and the preparation of any closure or other required plans.

19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to have been given upon receipt.

TO: COUNTY

County of Orange
Social Services Agency
Facilities Services
500 N. State College Boulevard
Orange, CA 92868

With a copy to:

County Executive Office
Attention: Chief Real Estate Officer
333 W. Santa Ana Boulevard, 3rd Floor
Santa Ana, CA 92701

TO: LICENSEE

CalOptima
15496 Magnolia, #111
Westminster, CA 92806
Phil Tsunoda, Executive Director,
Public Policy & Public Affairs
ptsunoda@caloptima.org

20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Exhibit A - License Description
Exhibit B – Floor Plan

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WITNESS WHEREOF, the parties have executed this License the day and year first above written

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy County Counsel

Date: 8/25/16

LICENSEE
CalOptima

By _____

Name: Michael Schrader
Title: CEO

RECOMMENDED FOR APPROVAL

Social Services Agency

By _____
Carol Wiseman, Chief Deputy Director

CEO Real Estate Services

By _____
John Buck, Administrative Manager

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date: 8.29.16

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GENERAL CONDITIONS (AMLC-GC l-17 S)

1. PERMITS AND LICENSES (AMLC - GC2 S)

LICENSEE shall be required to obtain any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by COUNTY, in its governmental capacity, shall affect or limit LICENSEE's obligations hereunder, nor shall any approvals or consents given by COUNTY, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

2. SIGNS (AMLC-GC3 S)

LICENSEE agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by Facilities Operations Manager unapproved signs, banners, flags, etc., may be removed.

3. LICENSE ORGANIZATION (AMLC-GC4 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

4. AMENDMENTS (AMLC-GC5 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

5. UNLAWFUL USE (AMLC-GC6 S)

LICENSEE agrees no improvements shall be erected, placed upon, operated, nor maintained on the License Area, nor any business conducted or carried on therein or there from, in violation of the terms of this License, or of any regulation, order of law, statute, bylaw, or ordinance of a governmental agency having jurisdiction.

6. INSPECTION (AMLC-GC7 S)

COUNTY or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

7. INDEMNIFICATION (AMLC-GC8 S)

LICENSEE hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of persons or property arising from, growing out of, or in any way connected with or related to this License except claims arising from the concurrent active or sole negligence of COUNTY, its officers, agents, and employees. LICENSEE hereby agrees to indemnify, hold harmless, and defend with counsel acceptable to COUNTY, its officers, agents, and employees against any and all claims, loss, demands, damages, cost, expenses, or liability costs arising out of the operation, use, or maintenance of the property

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described herein, and/or LICENSEE's exercise of the rights under this License, except for liability arising out of the concurrent active or sole negligence of COUNTY, its officers, agents, or employees, including the cost of defense of any lawsuit arising there from.

In the event COUNTY is named as co-defendant, LICENSEE shall notify COUNTY of such fact and shall represent COUNTY with counsel acceptable to COUNTY in such legal action unless COUNTY undertakes to represent itself as co-defendant in such legal action, in which event LICENSEE shall pay to COUNTY its litigation costs, expenses, and attorney's fees. In the event judgment is entered against COUNTY and LICENSEE because of the concurrent active negligence of COUNTY and LICENSEE, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

8. TAXES AND ASSESSMENTS (AMLC-GC9 S)

Although not anticipated, should this License create a possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all taxes and assessments (including but not limited to said possessory interest tax) which become due and payable in connection with this License or upon fixtures, equipment, or other property used in connection with this License, shall be the full responsibility of LICENSEE, and LICENSEE shall cause said taxes and assessments to be paid promptly.

9. PARTIAL INVALIDITY (AMLC-GC10 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

10. WAIVER OF RIGHTS (AMLC-GC11 S)

The failure of COUNTY to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that COUNTY may have, and shall not be deemed a waiver of the right to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

11. CONDITION OF LICENSE AREA UPON TERMINATION (AMLC-GC12 S)

Except as otherwise agreed to herein, upon termination of this License, LICENSEE shall redeliver possession of said License Area to COUNTY in substantially the same condition that existed immediately prior to LICENSEE's entry thereon, reasonable wear and tear, flood, earthquakes, and any act of war excepted.

12. DISPOSITION OF ABANDONED PERSONAL PROPERTY (AMLC-GC13 S)

If LICENSEE abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to LICENSEE and left on the License Area ten (10) days after such event shall be deemed, at COUNTY's option, to have been transferred to COUNTY. COUNTY shall have the

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right to remove and to dispose of such property without liability there from to LICENSEE or to any person claiming under LICENSEE, and shall have no need to account therefore.

13. TIME OF ESSENCE (AMLC-GC14 S)

Time is of the essence of this License. Failure to comply with any time requirements of this License shall constitute a material breach of this License.

14. NO ASSIGNMENT (AMLC-G15 S)

The License granted hereby is personal to LICENSEE and any assignment of said license by LICENSEE, voluntarily or by operation of law, shall automatically terminate the License granted hereby.

15. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (AMLC-GC16 S)

In order to comply with child support requirements of the County of Orange, LICENSEE hereby furnishes COUNTY's Facilities Operations Manager, COUNTY's standard form, Child Support Enforcement Certification Requirements. COUNTY acknowledges receipt of the aforementioned form, which contains the following information:

a) In the case where LICENSEE is doing business as an individual, LICENSEE's name, date of birth, Social Security number, and residence address;

b) In the case where LICENSEE is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

c) A certification that LICENSEE has fully complied with all applicable federal and state reporting requirements regarding its employees; and

d) A certification that LICENSEE has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to so comply.

Failure of LICENSEE to continuously comply with all federal and state reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this License. Failure to cure such breach within sixty (60) calendar days of notice from COUNTY's shall constitute grounds for termination of this License.

It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.

16. RIGHT TO WORK AND MINIMUM WAGE LAWS (AMLC-GC17 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LICENSEE shall require its employees that directly or indirectly service the License Area or terms and conditions of this License, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LICENSEE shall also require and verify that its contractors or any other persons servicing the License Area

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or terms and conditions of this License, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LICENSEE shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. LICENSEE shall require and verify that all its contractors or other persons servicing the License Area on behalf of LICENSEE also pay their employees no less than the greater of the Federal or California Minimum Wage.

LICENSEE shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the License Area or terms and conditions of this License.

Notwithstanding the minimum wage requirements provided for in this clause, LICENSEE, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

17. BEST MANAGEMENT PRACTICES (AMLC 15.1 S)

LICENSEE and all of LICENSEE's, agents, employees and contractors shall conduct operations under this License so as to assure that pollutants do not enter municipal storm drain systems which systems are comprised of, but are not limited to curbs and gutters that are part of the street systems ("**Stormwater Drainage System**"), and to ensure that pollutants do not directly impact "**Receiving Waters**" (as used herein, Receiving Waters include, but are not limited to, rivers, creeks, streams, estuaries, lakes, harbors, bays and oceans).

The Santa Ana and San Diego Regional Water Quality Control Boards have issued National Pollutant Discharge Elimination System ("**NPDES**") permits ("**Stormwater Permits**") to the County of Orange, and to the Orange County Flood Control District and cities within Orange County, as co-permittees (hereinafter collectively referred to as "**County Parties**") which regulate the discharge of urban runoff from areas within the County of Orange, including the License Area. The County Parties have enacted water quality ordinances that prohibit conditions and activities that may result in polluted runoff being discharged into the Stormwater Drainage System.

To assure compliance with the Stormwater Permits and water quality ordinances, the County Parties have developed a Drainage Area Management Plan ("**DAMP**") which includes a Local Implementation Plan ("**LIP**") for each jurisdiction that contains Best Management Practices ("**BMP(s)**") that parties using properties within Orange County must adhere to. As used herein, a BMP is defined as a technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in a cost effective manner. These BMPs are found within the COUNTY's LIP in the form of Model Maintenance Procedures and BMP Fact Sheets (the Model Maintenance Procedures and BMP Fact Sheets contained in the DAMP/LIP shall be referred to hereinafter collectively as "**BMP Fact Sheets**") and contain pollution prevention and source control techniques to eliminate non-stormwater discharges and minimize the impact of pollutants on stormwater runoff.

The use under this License does not require BMP Fact Sheets.

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18. PAYMENT CARD COMPLIANCE (AMLC-G15 S)

Should LICENSEE conduct credit/debit card transactions in conjunction with their business with the COUNTY, on behalf of the COUNTY, or as part of the business that they conduct, LICENSEE covenants and warrants that it is currently Payment Card Industry Data Security Standard (**"PCI DSS"**) and Payment Application Data Security Standards (**"PA DSS"**) compliant and will remain compliant during the entire duration of this License. LICENSEE agrees to immediately notify COUNTY in the event LICENSEE should ever become non-compliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

Upon demand by COUNTY, LICENSEE shall provide to COUNTY written certification of LICENSEE's PCI DSS and/or PA DSS compliance.

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LICENSE DESCRIPTION (10.1 S)

PROJECT NO: GA 1213-236 DATE: 6/29/16

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's non-exclusive use, which space may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT A

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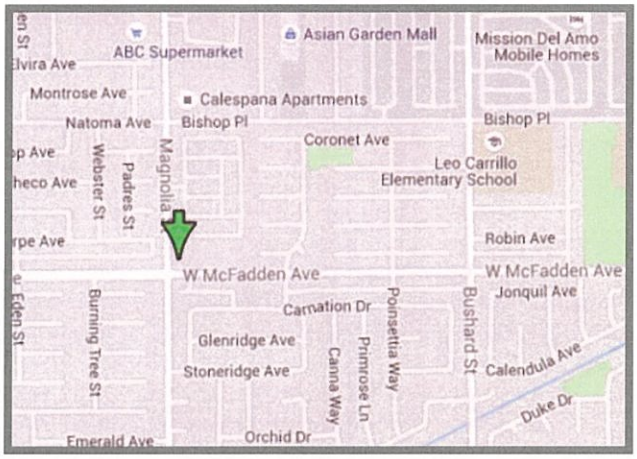
GA 1213-237
SSA/CalOptima



Location Map

N

License Area:
Rooms 1 & 2

15496 Magnolia St. Suite 111 Westminster Ca. 92683

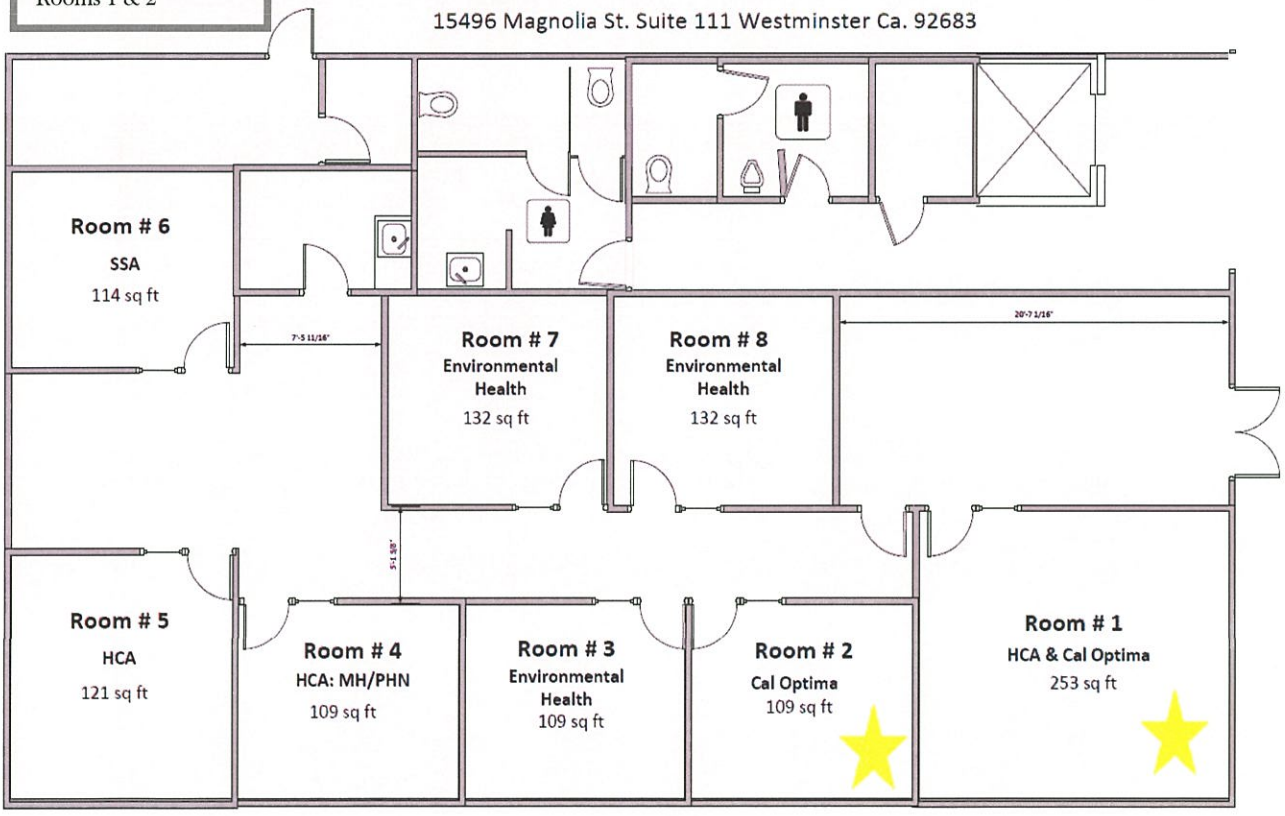


EXHIBIT B

CCSC COST APPLY - 15496 Magnolia Street, Westminster

FY 2017-18 MONTHLY INVOICE CODING SUMMARY

Invoice Coding and Job Number Allocation.

	Fund/Dept/Budget Control Unit/Object/Job No.	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
CalOptima	100/063/063 2211/2200/S34009	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	**$ 18,731.77**

LEASED SPACE

	Fund/Dept/Budget Control /Unit/Object/Job No	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/2200/S34009**	**235.55**	**21.83%**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 17,090.27**

Total leased space: 1079 sq. ft.

Lease rates: Monthly Fiscal Year total:

Rent: July 1, 2017 - June 30, 2018 $ 6,524.00 $ 78,288.00

Operating Expenses

charge by Charles H Manh and Anh Manh	Fund/Dept/Budget Control /Unit/Object/Job No	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Total leased space: 1079 sq. ft.

Monthly Fiscal Year total:

Operating Expenses: July 1 2017 - June 30, 2018 $ - $ -

IT SERVICES - Internet by Time W

	Fund/Dept/Budget Control /Unit/Object	# computers	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**1**	**16.67%**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 790.02**

Monthly IT rates $ 395.01 2016-17 Rate + 2.60% CPI

Annual High Speed Internet Service Cost $ 4,740.12

TELEPHONE SERVICES

	Fund/Dept/Budget Control /Unit/Object	# phones	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**1**	**12.50%**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 231.25**

Monthly Average Telephone Service Costs $ 154.17 2016-17 Rate + 2.60% CPI

Annual Telephone Service Costs $ 1,850.00

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JANITORIAL SERVICES	Fund/Dept/Budget Control /Unit/Object	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total		
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		

Total leased space: 1079 sq. ft.

Monthly Janitorial Costs $ - 2016-17 Rate + 2.60% CPI
12 mo. Annual Janitorial Costs $ -

ELECTRICAL/UTILITIES Acct 3045332860 by Al Pasillas	Fund/Dept/Budget Control /Unit/Object	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total		
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 620.23**		

Total leased space: 1079 sq. ft.

Average Utility Costs $ 236.76 2016-17 Rate + 2.60% CPI
12 mo. Annual Janitorial Costs $ 2,841.17

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FIRST AMENDMENT TO LICENSE

This FIRST AMENDMENT TO LICENSE AGREEMENT (**"First Amendment"**) is made and entered into August 23, 2017, by and between CALOPTIMA (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**" or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, State of California, License Area, pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The term of this License commenced on August 4, 2016, and will terminate on June 30, 2017.

III. The Parties have agreed to amend the License to extend the term for four (4) additional years.

NOW, THEREFORE, in consideration of the Recitals, above, incorporated by reference herein, and the mutual covenants and agreements hereinafter contained, COUNTY and LICENSEE mutually agree to amend the License effective July 1, 2017 (**"Effective Date"**) as follows:

A. Clause 2. [TERM (AMLC-3.1N)] is hereby deleted in its entirety from the License and replaced with the following:

"2. TERM (AMLC-3.1 N)

The term of this License commenced on August 4, 2016 and shall terminate on June 30, 2021 ("**Term**"). Said License shall continue in effect for the Term, unless otherwise terminated as provided in Clause 3 (TERMINATION) of this License.

B. Clause 4. [LICENCE AREA (AMLC-4.2N)] is hereby deleted in its entirety from the License and replaced with the following:

"4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the exclusive right to use that certain property referred to as Room #2 and non-exclusive right to use that certain property referred to as Room #1. hereinafter referred to as **"License Area,"** described on Revised Exhibit A and shown on Exhibit B, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, parking, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

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During the term of this License, the dates and times for use of Room #1of the License Area will be determined by the Facilities Services Manager to ensure LICENSEE has access to Room #1 for fifty percent (50%) of the time, and the location of Room #2 as shown on Exhibit B of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

C. Clause 6. [USE (AMLC-5.1 N)] is hereby deleted in its entirety from the License and replaced with the following:

"6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their CalOptima Programs, to store CalOptima materials, and to provide private space to meet with CalOptima Members or potential members.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

D. Clause 7. [LICENCE FEE (AMLC-6.1S)] is hereby deleted in its entirety from the License and replaced with the following:

"7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the Effective Date of this License according to the following schedule:

Commencing	Monthly License Fee
July 1, 2017	$1,560.98
July 1, 2018	$1,607.81
July 1, 2019	$1,656.04
July 1, 2020	$1,705.72

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month.

E. Clause 10. [UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N) is hereby deleted in its entirety from the License and replaced with the following:

"10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas, electricity and sewer). County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). LICENSEE shall be responsible for telephone service, internet service and janitorial service.

F. Clause 14. [INSURANCE (AML-10.1S)] is hereby deleted in its entirety from the License and replaced with the following:

"14. INSURANCE (AML-6.1 S)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with the COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy the COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with the COUNTY during the entire term of this License.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Service Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Service Manager will only accept valid certificates of insurance and endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Service Manager reinstates the License.

If LICENSEE fails to provide Facilities Service Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Service Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

LICENSEE may occupy the [Premises] only upon providing to County the required insurance stated herein and maintain such insurance for the entire term of this LICENSE. County reserves the right to terminate this LICENSE at any time LICENSEE's insurance is canceled or terminated and not reinstated within ten (10) days of said cancellation or termination. LICENSEE shall provide to County immediate notice of said insurance cancellation or termination.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by the COUNTY from the LICENSEE under this License. It is the obligation of the LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.

All self-insured retentions (SIRs) shall be clearly stated on the Certificate of Insurance. Any self-insured retention (SIR) in an amount in excess of Fifty Thousand Dollars ($50,000) shall specifically be approved by the County's Risk Manager, or designee, upon review of LICENSEE's current audited financial report. If LICENSEE's SIR is approved, LICENSEE, in addition to, and without limitation of, any other indemnity provision(s) in this License, agrees to all of the following:

1) In addition to the duty to indemnify and hold the County harmless against any and all liability, claim, demand or suit resulting from LICENSEE's, its agents, employee's or subcontractor's performance of this Agreement, LICENSEE shall defend the County at its sole cost and expense with counsel approved by Board of Supervisors against same; and
2) LICENSEE's duty to defend, as stated above, shall be absolute and irrespective of any duty to indemnify or hold harmless; and
3) The provisions of California Civil Code Section 2860 shall apply to any and all actions to which the duty to defend stated above applies, and the LICENSEE's SIR provision shall be interpreted as though the LICENSEE was an insurer and the County was the insured.

If the LICENSEE fails to maintain insurance acceptable to the COUNTY for the full term of this License, the COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by the LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence

Coverages	Minimum Limits
	$2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence
Commercial Property Insurance on an "All Risk" or "Special Causes of Loss" basis covering all, contents and any tenant improvements including Business Interruption/Loss of Rents with a 12 month limit.	100% of the Replacement Cost Value and no coinsurance provision

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (ISO) form CG 00 01, or a substitute form providing liability coverage at least as broad.

The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The Commercial General Liability policy shall contain the following endorsements, which shall accompany the Certificate of insurance:

1) An Additional Insured endorsement using ISO form CG 20 26 04 13 or a form at least as broad naming the ***County of Orange, its elected and appointed officials, officers, employees, agents*** as Additional Insureds. Blanket coverage may also be provided which will state- ***As Required By Written Agreement***.
2) A primary non-contributing endorsement using ISO form CG 20 01 04 13, or a form at least as broad, evidencing that the LICENSEE's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing.

The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the ***County of Orange, its elected and appointed officials, officers, agents and employees***. Blanket coverage may also be provided which will state- ***As Required By Written Agreement.***

All insurance policies required by this license shall waive all rights of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

The Commercial Property policy shall contain a Loss Payee endorsement naming the County of Orange as respects the County's financial interest when applicable.

LICENSEE shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the LICENSE, upon which the County may suspend or terminate this LICENSE.

The Commercial General Liability policy shall contain a severability of interests clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to the COUNTY address provided in the Clause (NOTICES) below or to an address provided by Facilities Service Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by County of Orange Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

G. Clause 17. [HIPAA (N)] is hereby deleted from the License in its entirety.

H. Clause 18. [HAZARDOUS MATERIALS (AMLC-16.1S)] is hereby deleted from the License in its entirety.

I. Clause 19. [NOTICES (AMLC-14.1S)] is hereby deleted from the License in its entirety and replaced with the following:

"19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to

have been given upon receipt.

TO: COUNTY	TO: LICENSEE
County of Orange Social Services Agency Facilities Services 500 N. State College Boulevard Orange, CA 92868 Attention: Facilities Services Manager	CalOptima 505 City Parkway West Orange, CA 92868 Attention: Chief Executive Officer mschrader@caloptima.org
With a copy to:	With a copy to:
County Executive Office 333 W. Santa Ana Boulevard, 3rd Floor Santa Ana, CA 92701 Attention: Chief Real Estate Officer	CalOptima 505 City Parkway West Orange, CA 92868 Attention: Legal Counsel gcrockett@caloptima.org

J. Clause 20. [ATTACHMENTS TO LICENSE (AMLC-15.1S)] is hereby deleted from the License in its entirety and replaced with the following:

"**20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)**

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Revised Exhibit A - License Description
Exhibit B – Floor Plan

K. Wherever a conflict in the terms or conditions of this First Amendment and the License exists, the terms or conditions of this First Amendment shall prevail. In all other respects, the terms and conditions of the License not specifically changed by this First Amendment shall remain in full force and effect.

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IN WITNESS WHEREOF, the Parties have executed this First Amendment the day and year first above written.

APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy

Date: 8/21/17

LICENSEE
CALOPTIMA

By _____
Name: Michael Schrader
Title: CEO

RECOMMENDED FOR APPROVAL

SOCIAL SERVICES AGENCY

By _____
Carol Wiseman, Chief Deputy Director

COUNTY EXECUTIVE OFFICE

By _____
Administrative Manager
Real Estate Services

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date: 8.23.17

REVISED EXHIBIT A

LICENSE DESCRIPTION (10.1 S)

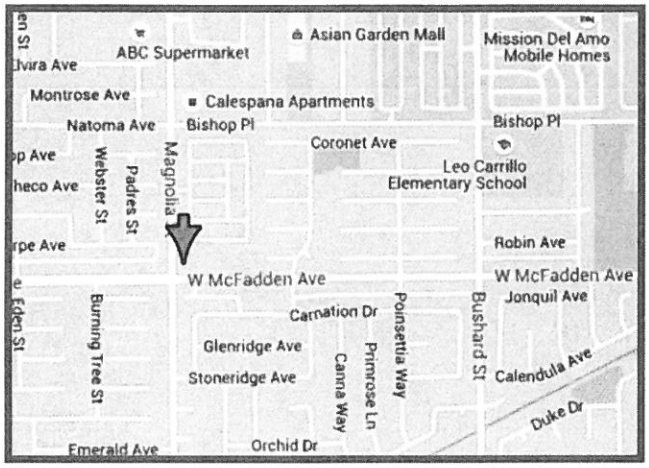
PROJECT NO: GA 1213-236 DATE: 6/13/17

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being a total of Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's use, which consists of approximately One Hundred Nine (109) rentable square feet identified as Room #2 that shall be exclusive to LICENSEE, and the remaining Two Hundred Fifty Three (253) rentable square feet shall be non-exclusive, identified as Room #1. License Area may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot. The parties acknowledge that in the event Room #1 is expanded to include the common area immediately adjacent, such expanded area shall be included in the License Area.

NOT TO BE RECORDED



Location Map

N

License Area:
Rooms 1 & 2

15496 Magnolia St. Suite 111 Westminster Ca. 92683

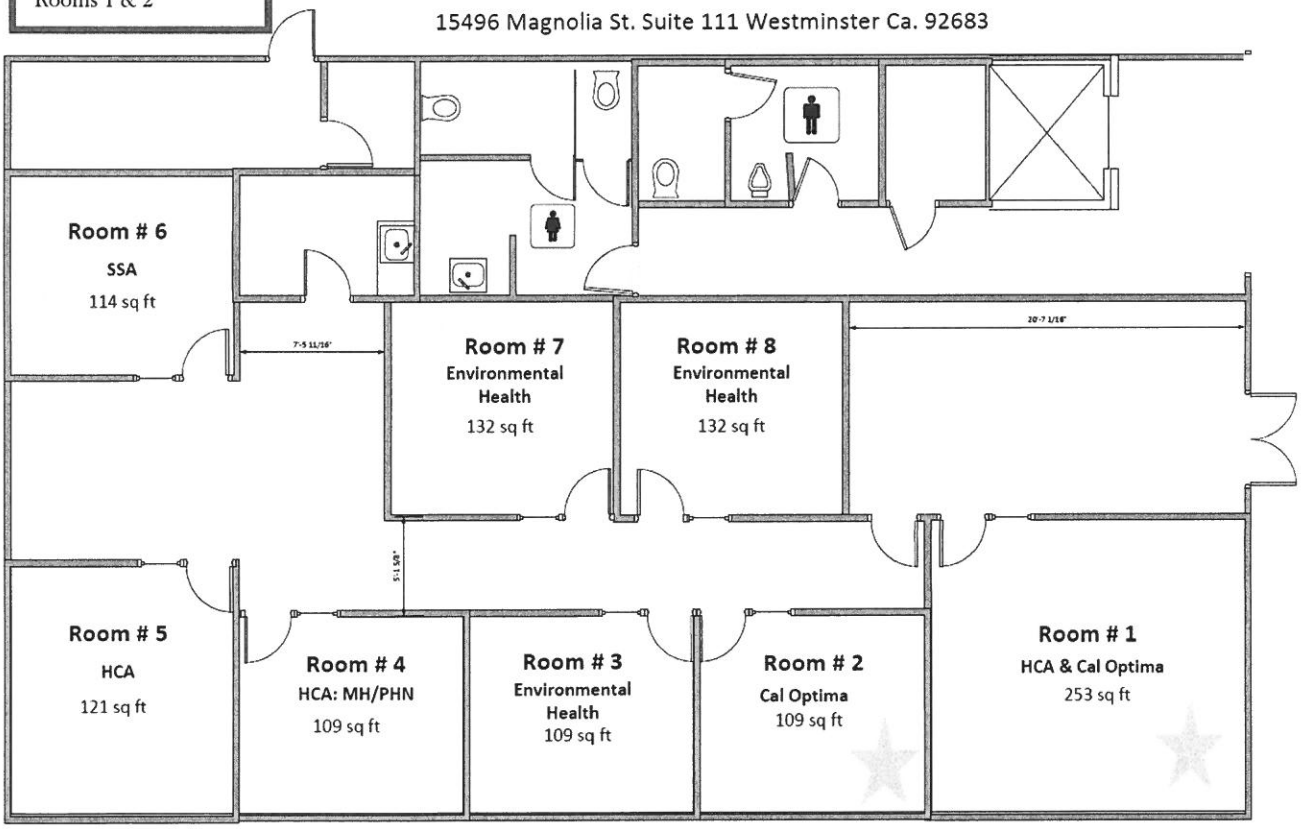


EXHIBIT B

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Attachment F

West Annex Community Customer Service Center
15496 Magnolia Street
Westminster, CA 92683

~~LEASE~~FIRST AMENDMENT TO LEASE

THIS FIRST AMENDMENT TO LEASE (**"First Amendment"**) is made _____, 2017 (**"Effective Date"**) by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006, (hereinafter referred to as **"LESSOR"**), and the COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**), without regard to number and gender. LESSOR and COUNTY may individually be referred to herein as a "**Party"** and collectively as the **"Parties."**

~~THIS IS A LEASE (hereinafter referred to as "**Lease**"), made July 1, 2016, ("**Effective Date**") by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006 ("**LESSOR**") and the COUNTY OF ORANGE, a political subdivision of the State of California ("**COUNTY**"), without regard to number and gender. The LESSOR and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**.~~

R E C I T A L S

I. Pursuant to a lease agreement dated July 1, 2016 (**"Lease"**), LESSOR leases to COUNTY approximately 2,120 rentable square feet of office space (**"Premises"**) in the building located at 15496 Magnolia Street, in the City of Westminster, California (**"Building"**) for use by the Social Services Agency, which Premises is more particularly described on Exhibit A and Exhibit B of the Lease.

II. The original Lease term of one (1) year commenced on July 1, 2016.

III. LESSOR and COUNTY are willing to amend the Lease to extend the term of the Lease for an additional four (4) years through June 30, 2021 under the terms and conditions set forth below.

1. DEFINITIONS (1.2 S)

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"CEO Real Estate"" means the County Executive Office's Real Estate team, or upon written notice to LESSOR, such other person or entity as shall be designated by the Chief Real Estate Officer, County of Orange, or designee.

"Chief Real Estate Officer" means the Chief Real Estate Officer for the County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or r the Board of Supervisors.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"Risk Manager" means the Risk Manager, County Executive Office, Risk Management, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. PREMISES (1.3 S)

LESSOR leases to COUNTY that certain property consisting of 2,120 square feet, located at 15496 Magnolia Street, Suite 111, Westminster, CA and described in Exhibit A and shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as "**Premises**"),, together with non-exclusive, in common use of LESSOR's elevators, stairways, washrooms, hallways, parking areas, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to the Premises created by this Lease.

3. PARKING (1.4 S)

LESSOR, throughout the term of this Lease, shall provide a total of thirteen (13) parking spaces for COUNTY's free and non-exclusive use. Said parking spaces are to be located in the parking areas adjacent to the Premises. LESSOR shall designate three (3) parking spaces adjacent to the Premises to be reserved for use by COUNTY clients. Said parking spaces shall contain signs above the space indicating that the spaces are reserved for COUNTY use.

In addition to said parking spaces, LESSOR shall also provide parking for disabled persons in accordance with the Americans with Disabilities Act, Section 7102 of the California Uniform Building Code and the applicable codes and/or ordinances relating to parking for disabled persons as established by the local

jurisdiction in which the Premises is located where the provisions of such local codes and/or ordinances exceed or supersede the State requirements.

A. Clause 4. TERM (2.2 N) is hereby deleted in its entirety from the Lease and replaced with the following:

4. TERM (2.2 N)

The term of this Lease commenced on July 1, 2016 (**"Commencement Date"**), and will terminate on June 30, 2021 (**"Term"**)."~~The term of this Lease shall be one (1) year ("**Term**"), commencing upon the first of the next month following execution of this Lease by the COUNTY Chief Real Estate Officer or upon LESSOR's delivery and COUNTY's acceptance of the Premises, whichever is later ("**Commencement Date**").~~

~~Parties agree that the Commencement Date of this Lease will be confirmed in writing by either Party upon demand by the other.~~

B. Clause 5. RENT (3.1 N) is hereby deleted in its entirety from the Lease and replaced with the following:

5. RENT (3.1 N)

~~COUNTY agrees to pay LESSOR as rent for the Premises the sum of Five Thousand Dollars ($5,000.00) per month~~ ~~pursuant to the following rent payment schedule ("**Rent**").~~

~~MONTH~~	~~MONTHLY RENT~~	~~MONTH~~	~~MONTHLY RENT~~
~~1~~	~~$0.00~~	~~7~~	~~$5,000.00~~
~~2~~	~~$0.00~~	~~8~~	~~$5,000.00~~
~~3~~	~~$5,000.00~~	~~9~~	~~$5,000.00~~
~~4~~	~~$5,000.00~~	~~10~~	~~$5,000.00~~
~~5~~	~~$5,000.00~~	~~11~~	~~$5,000.00~~
~~6~~	~~$5,000.00~~	~~12~~	~~$5,000.00~~

The monthly rent payable by COUNTY for the Premises shall be automatically adjusted as follows:

Attachment F

Commencing	Monthly Rent	Per Square Foot
July 1, 2017	$6,524	$3.08
July 1, 2018	$6,720	$3.17
July 1, 2019	$6,921	$3.26
July 1, 2020	$7,129	$3.36

The "Monthly Rent," above, is the amount to be paid by the COUNTY. The "Per Square Foot" rate, above, is an estimate for statistical purposes only and for no other purpose.

To obtain rent payments LESSOR (or LESSOR's designee) shall submit to the COUNTY, in a form acceptable to said COUNTY, a written claim for payment of applicable Rent and COUNTY's share of the NNN Expenses, as defined in Section 6, below.
Payment shall be due and payable by direct deposit into a bank account specified by LESSOR within twenty (20) days after the later of the following:

A. The first day of the month following the month earned; or
B. Receipt of LESSOR's written claim by COUNTY.

Should COUNTY occupy the Premises before the Commencement Date, LESSOR shall be entitled to pro rata Rent for the period of occupancy occupied prior to the Commencement Date based upon the monthly Rent above. Said Rent shall be included in the rent claim submitted by LESSOR for the first full month of the Term and shall be paid by COUNTY at the time of payment for said month.

6. REIMBURSEMENT OF LESSOR'S OPERATING EXPENSES (6.0 N)

LESSOR and COUNTY agree pursuant to Section 5, above, that COUNTY shall pay the fixed amount of $657.20 ($.31/sf/mo.) per month for the term of the lease, as reimbursement for COUNTY's pro rata share of LESSOR's expenses related to the items described in Section 6A, 6B, 6C and 6D of this Lease for the property in which the Premises is located ("**NNN Expenses**"). LESSOR shall submit to COUNTY a separate monthly invoice .in addition to the monthly Rent invoice.

The pro rata share of LESSOR's NNN Expenses as defined above is determined according to the gross leasable area of the Premises as it relates to the total gross leasable area of the building that contains the Premises. The percent of COUNTY's occupancy which LESSOR and COUNTY agree is 12.47% (the "**pro rata share**"): the Premises is 2,120 gross square feet; and the total building area is 17,000 gross square feet.

COUNTY shall reimburse LESSOR for COUNTY's pro rata share of the NNN Expenses only for the items in Section 6A, 6B and 6C and 6D below:

A. Property Taxes and Property Tax Assessments pursuant to Section 13 of this Lease.
B. Maintenance and repair, and janitorial services for the common area restrooms in the building in which the Premises is located pursuant to Section 9 of this Lease.
C. Common area maintenance and repair of the building, parking lots, landscaping, lighting, and other common area maintenance and repair costs pursuant to Section 9 of this Lease.
D. Commercial Property Insurance and Commercial General Liability Insurance pursuant to Section 11 of this Lease.

7. ALTERATIONS (4.4 S)

COUNTY may make improvements and changes in the Premises, including but not limited to the installation of fixtures, partitions, counters, shelving, and equipment as deemed necessary or appropriate. It is agreed that any such fixtures, partitions, counters, shelving, or equipment attached to or placed upon the Premises by COUNTY shall be considered as personal property of COUNTY, who shall have the right to remove same. COUNTY agrees that the Premises shall be left in as good condition as when received, reasonable wear and tear excepted.

8. ORANGE COUNTY INFROMATION TECHNOLOGY SYSTEM S (OCIT) (4.5 N)

LESSOR agrees that COUNTY may install, at COUNTY's sole cost and expense, computer and telecommunication devices in, on, or around the Premises and LESSOR's building in accordance with COUNTY's plans and specifications provided that the provisions of the Clause entitled ALTERATIONS, of this Lease, shall be applicable to such work. It shall be COUNTY's responsibility to obtain all governmental permits and/or approvals required for such installation; however, LESSOR shall reasonably cooperate with COUNTY as necessary or appropriate, to obtain said permits and/or approvals.

9. Clause 9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 S) is hereby deleted from the Lease and the following is substituted:

"9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 N)

1. **Lessor Services.** LESSOR shall provide, at its sole cost and expense, except as otherwise provided in this Lease, any and all necessary repair, maintenance and replacement for the Premises and Building and systems therein in good order, condition and repair and in compliance with all applicable laws, including, but not limited to, the replacement, repair and maintenance of the structural portions of the Building, the roof of the Building, the parking facilities and all Building systems including the Heating, Ventilation, Air Conditioning (**"HVAC"**) system, the plumbing

with the exception that COUNTY shall reimburse LESSOR for any expense incurred for repairing plumbing defects caused by the introduction of foreign matter into the plumbing fixtures, electrical and mechanical systems, fire/life safety system, elevators, roof, paving, fire extinguishers and pest control, and whether capital or non-capital (collectively, and together with the janitorial services described in Clause 9(D) below, the **"Services"**). Upon request, LESSOR shall provide COUNTY with a complete copy of the janitorial and any other contracts for Services of an ongoing nature. Any repairs or replacements performed by LESSOR must be at least equal in quality and workmanship to the original work and be in accordance with all applicable laws. Such repair, maintenance and replacement shall be made promptly to keep the Premises and the Building in the condition described in this Clause 9. Should LESSOR default in its obligations under this clause, the COUNTY may exercise those remedies set forth in Clause 9(B) of this Lease.

2. **County Remedies**. If LESSOR fails to provide the Services within fifteen (15) days after SSA/Facilities Services Manager provides written notice thereof to LESSOR specifying any such default and affording LESSOR such fifteen (15) day period to complete the cure of such default, provided, however, that if the cure cannot reasonably be completed within such time period, LESSOR shall be afforded an additional reasonable amount of time to complete the cure, as long as LESSOR commences the cure within such time period and diligently pursues same to completion, without limiting any available remedy to COUNTY, COUNTY may, upon written notice to LESSOR and LESSOR's lender, to the extent contact information for such lender has been provided in writing to COUNTY, and, at its sole discretion, perform or arrange for the performance of such Services, and deduct the cost thereof plus and administrative charge of ten percent (10%) of the cost from any Monthly Rent payable without further notice. Additionally, in the event that LESSOR fails to provide required Services to the Premises sixty (60) days after the 15-day written notice, above, to LESSOR, LESSOR shall be obligated to pay a penalty to COUNTY of Twenty Five Dollars ($25) per day until such Services are provided by LESSOR.

3. **Warranties**. LESSOR shall initiate at purchase, and keep in force, all manufacturers' warranties including extended warranties for all building equipment. When manufacturer's warranties for the HVAC, roof and elevator expire, LESSOR will contract with an industry standard maintenance company ("**Vendor"**) that specializes in the maintenance of such equipment (and for the roof) for regular and scheduled inspections as recommended by the manufacturer, and immediately authorize said Vendor to perform any and all recommended maintenance to the equipment upon receipt of any inspection report. LESSOR shall authorize Vendors to provide COUNTY with copies of said reports upon COUNTY request. Should LESSOR fail to comply with the provisions of this clause, COUNTY may exercise those remedies set forth in Clause 9(B).

4. **Janitorial Services**. Janitorial supplies and services shall be provided to the Premises consistent with the past practices of LESSOR at the Premises during COUNTY's tenancy on a five (5) day- per-week basis in accordance with Exhibit D (JANITORIAL SPECIFICATIONS). In addition, upon request of COUNTY, LESSOR agrees to provide a copy of the contract with janitorial services as described in Exhibit D, to COUNTY. LESSOR understands that these services are a material consideration of this Lease to COUNTY. Should LESSOR fail to comply with the provisions of this Clause, COUNTY may exercise those remedies set forth in Clause 9(B).

5. **Code Compliance**. LESSOR shall be 100% responsible throughout the Term for any cost in the Premises, including all parking facilities, walkways, entrances, hallways and other public spaces, restrooms, and other devices or pathways for ingress and egress to the Premises regardless of cause with all the requirements of the Americans with Disabilities Act ("**ADA**") and all regulations issued by the U. S. Attorney General or other agencies under the authorization of the ADA, California Building Code, Title 24, Seismic Code, Fire and Life Safety requirements and, if applicable, California Green Building Standard Code. However, LESSOR shall not be responsible for any ADA violations resulting from alterations made by COUNTY or the placement of COUNTY's furniture, fixtures or equipment by COUNTY. LESSOR agrees to reimburse and indemnify, and defend COUNTY for any expenses incurred because of the failure of the Premises to conform with the above cited law and regulations, including the costs of making any alterations, renovations, or accommodations required by the ADA, or any governmental enforcement agency, or any court, any and all fines, civil penalties, and damages awarded against COUNTY resulting from a violation or violations of the above-cited law and regulations, and all reasonable legal expenses incurred in defending claims made under the above-cited law and regulations, including reasonable attorneys' fees. Should LESSOR fail to comply with the provisions of this Clause, the COUNTY may exercise those remedies set forth in Clause 9(B).

6. **HVAC System**. Air conditioning will be supplied to cause the temperature in Premises at a temperature consistent with other office buildings in Orange County, California, which are typically not less than **73**° F nor greater than °**75** F, during all COUNTY Working Hours.

Said temperature requirements shall be maintained during COUNTY's normal business operating hours (**"COUNTY Working Hours"**) which are:

Hours of Operation	Days of Operation
8:00 a.m. to 6:00 p.m.	Monday through Friday

Except for COUNTY Holidays, which holidays shall be provided to LESSOR on a yearly basis upon request to COUNTY. Some additional overtime hours may be used from time-to-time on any day, including Sundays, but said overtime hours shall be restricted to a timer or other limiting measures agreed to by LESSOR and COUNTY.

Notwithstanding the utilities provided during COUNTY Working Hours, LESSOR shall provide HVAC services prior to the beginning of COUNTY Working Hours in order for the temperature parameters required by this Lease, above, to be met and maintained at the beginning and throughout COUNTY Working Hours. There shall be no extra utility charges for HVAC services prior to the beginning of COUNTY Working Hours.

In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142 (**"Regulation 5142"**), and as it may be subsequently amended, LESSOR shall regularly inspect and maintain the HVAC system as required by Regulation 5142 and provide repair and maintenance accordingly. Inspections and maintenance of the HVAC system shall be documented in writing and LESSOR shall retain such records for at least five (5) years. LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY in a timely manner and as set forth herein, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any Monthly Rent payable without further notice.

7. **Emergency Services.** If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs, as determined by the COUNTY, and/or Services the same day any emergency repairs and/or Services are necessary to remedy the emergency condition or to prevent imminent danger to persons or property, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary emergency repairs or provide the necessary Services, COUNTY may at its option have the necessary repairs made and/or provide Services to remedy the emergency condition, and deduct the cost thereof, including labor, materials, and overhead from any Monthly Rent payable without further notice.

8. **County Misconduct**. In the event any damage to the Premises or any systems therein is caused as a result of the negligence or willful misconduct of COUNTY employees or contractors, repairs are to be made by LESSOR, but the cost of such repairs shall be reimbursed by COUNTY, together with an administrative fee of five percent (5%) of such cost, within sixty (60) days from receipt of an invoice by LESSOR detailing materials and labor and paid in accordance with Clause 5 (RENT).

A. **Operations Shutdown.**

B. Should COUNTY be forced to completely shut down its operations within the Premises due to LESSOR's failure to provide Services required by this Clause 9 for a period of three (3) consecutive days, excluding weekends and holidays, and subject to the provisions of Section 4 of the General Conditions to this Lease, LESSOR shall be obligated to pay a penalty to COUNTY of Two Hundred Dollars ($200) per day. Should LESSOR's obligation to pay a penalty arise as a result of a shut down due to LESSOR's failure to provide said Services as set forth herein, LESSOR shall pay COUNTY within thirty (30) days of written notice. Should LESSOR fail to pay COUNTY within thirty (30) days, COUNTY may deduct the amount of the penalty from any Monthly Rent payable without further notice."

~~**9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES** (5.1 N)~~

~~LESSOR shall keep, maintain, and repair the building and other improvements upon the Premises in good and sanitary order and condition (except as otherwise provided in this Lease) including without limitation, the maintenance and repair of the roof, parking lot, sidewalks, common area restrooms including janitorial supplies and services, landscaping, store front, doors, window casements, glazing, plumbing, pipes, electrical wiring, and conduits, and the heating and air conditioning system including the maintenance of a service contract with a heating and air conditioning contractor, as necessary to maintain the property in which the Premises is located in good and sanitary order, condition, and repair. COUNTY shall reimburse LESSOR for the County's pro rata share of said expenses in accordance with Section 6 of the Lease. Notwithstanding the language in the paragraph above, COUNTY shall provide at its own cost and expense all repair and maintenance and services to the interior of the Premises.~~

~~A. Heating, Ventilation and Air Conditioning System (HVAC)~~

~~During all operating hours the HVAC system serving the Premises, to be repaired and maintained by the LESSOR, shall be capable of maintaining the Premises at 78º Dry Bulb at a maximum range of 40% to 60% Relative humidity during the summer when the outdoor temperature is 95º Dry Bulb, and at 68º Dry Bulb in the winter when the outside temperature is 35º Dry Bulb.~~

~~In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142, and as it may be subsequently amended, LESSOR shall inspect the HVAC system at least once~~

annually or on a schedule agreed to in writing by LESSOR and COUNTY, and provide repair and maintenance accordingly. LESSOR's inspections and maintenance of the HVAC system shall be documented in writing. The LESSOR shall at a minimum, maintain a record of: (a) the name of the individual(s) inspecting and/or maintaining the system, (b) the date of the inspection and/or maintenance, and (c) the specific findings and actions taken. The LESSOR shall ensure that such records are retained for at least five (5) years. The LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request from COUNTY. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any rent payable.

B. Janitorial Supplies and Services

LESSOR shall provide janitorial supplies and services on a five day per week basis (Monday through Friday) to the common areas and common area restrooms in accordance with Exhibit D (JANITORIAL SPECIFICATIONS) attached hereto and by reference made a part hereof.

If LESSOR fails to provide satisfactory janitorial supplies to Premises, the Chief Real Estate Officer, or designee may notify LESSOR either verbally or in writing; and if LESSOR does not provide janitorial supplies within twenty-four (24) hours after LESSOR has received such written notice from COUNTY, COUNTY may provide the janitorial supplies necessary or have others do so, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs and/or services the same day any emergency repairs and/or services are necessary to remedy the emergency condition, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary repairs within a reasonable time or provide the necessary services, as determined by the Chief Real Estate Officer, COUNTY may at its option have the necessary repairs made and/or provide services to remedy the emergency condition, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

10. ELECTRIC UTILITIES (5.2 N)

COUNTY shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the interior of the Premises directly to the utility company.

LESSOR shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the exterior of the Premises and to the common areas of the property in which the Premises is located.

INSURANCE (5.3 S)

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against COUNTY by the insurance company issuing said policy or policies. LESSOR shall provide COUNTY with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

a. Name COUNTY as an additional insured;
b. Shall be primary, and any insurance or self-insurance maintained by COUNTY shall be excess and non-contributing;
c. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
d. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence; and
e. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It

is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

11. INDEMNIFICATION (5.5 A S)

C. Clause 11. INDEMNIFICATION (5.5 A S) is hereby deleted in its entirety from the Lease and replaced with the following:

"**Clause 11. INDEMNIFICATION (5.5 A S)**

COUNTY shall defend, indemnify and save harmless LESSOR and the LESSOR Parties, from and against any and all claims, demands, losses, or liabilities of any kind or nature which LESSOR or the LESSOR Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of COUNTY or the COUNTY Parties, in connection with the occupancy and use of the Premises by COUNTY or the COUNTY Parties.

Likewise LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties."~~LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties.~~

12. TAXES AND ASSESSMENTS (5.6 N)

All taxes and assessments which become due and payable upon the Premises shall be the full responsibility of LESSOR, and LESSOR shall cause said taxes and assessments to be paid prior to the due date. COUNTY shall reimburse LESSOR for its proportionate share of Taxes and Assessments pursuant to Section 5 of this Lease.

13. BUILDING AND SAFETY REQUIREMENTS (5.7 S)

During the full term of this Lease, LESSOR, at LESSOR's sole cost, agrees to maintain the Premises in compliance with all applicable laws, rules, regulations, building codes, statutes, and orders as they are applicable on the date of this Lease, and as they may be subsequently amended.

Included in this provision is compliance with the Americans with Disabilities Act ("**ADA**") and all other federal, state, and local codes, statutes, and orders relating to disabled access as they are applicable on the dates of this Lease, and as they may be subsequently amended.

LESSOR further agrees to maintain the Premises as a "safe place of employment," as defined in the California Occupational Safety and Health Act (California Labor Code, Division 5, Part 1, Chapter 3, beginning with Section 6400) and the Federal Occupational Safety and Health Act, where the provisions of such Act exceed, or supersede, the California Act, as the provisions of such Act are applicable on the date of this Lease, and as they may be subsequently amended.

In the event LESSOR neglects, fails, or refuses to maintain said Premises as aforesaid, COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, cure any such default by performance of any act, including payment of money, and subtract the cost thereof plus reasonable administrative costs from the rent.

14. TOXIC MATERIALS (5.9 S)

COUNTY hereby warrants and represents that COUNTY will comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive

matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "**Toxic Materials**"). COUNTY shall be responsible for and shall defend, indemnify and hold LESSOR, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the storage, use, and disposal of Toxic Materials on the Premises by COUNTY. If the storage, use, and disposal of Toxic Materials on the Premises by COUNTY results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, COUNTY shall promptly take any and all action necessary to clean up such contamination.

Likewise, LESSOR hereby warrants and represents that LESSOR has in the past and will hereafter comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "Toxic Materials"). LESSOR shall be responsible for and shall defend, indemnify and hold COUNTY, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the previous, current and future storage, use and disposal of Toxic Materials on the Premises (or building if the Premises comprises only a portion of said building) by LESSOR. If the previous, current and future storage, use, and disposal of Toxic Materials on the Premises by LESSOR results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, LESSOR shall promptly take any and all action necessary to clean up such contamination.

15. SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE (6.4 S)

This Lease and all rights of the COUNTY hereunder are subject and subordinate to any mortgage or deed of trust which does now or may hereafter cover the Premises or any interest of LESSOR therein, and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions of any such mortgage or deed of trust; except, insofar as COUNTY is meeting its obligations under this Lease, any foreclosure of any mortgage or deed of trust shall not result in the termination of this Lease or the displacement of COUNTY.

In the event of transfer of title to the Premises, including any proceedings brought for foreclosure or in the event of the exercise of the power of sale under any mortgage or deed of trust or by any other transfer of title covering the Premises, COUNTY shall attorn to and recognize any subsequent title holder as the

LESSOR under all terms, covenants and conditions of this Lease. COUNTY's possession of the Premises shall not be disturbed by the LESSOR or its successors in interest, and this Lease shall remain in full force and effect. Said attornment shall be effective and self-operative immediately upon succession of the current title holder, or its successors in interest, to the interest of LESSOR under this Lease.

Notwithstanding the above, this Lease is contingent upon LESSOR's obtaining a Subordination, Attornment and Non-Disturbance Agreement from LESSOR's lender, within thirty (30) days of LESSOR's execution of this Lease. LESSOR shall require all future lenders on the Premises upon initiation of their interest in the Premises, to enter into a Subordination, Attornment and Non-Disturbance Agreement with COUNTY thereby insuring COUNTY of its leasehold interests in the Premises. Said Subordination, Attornment and Non-Disturbance Agreement shall be in the form of COUNTY's standard form Subordination, Attornment and Non-Disturbance Agreement shown on Exhibit E, attached hereto and by reference made a part hereof, or in a form approved by the Chief Real Estate Officer, and County Counsel.

Foreclosure shall not extinguish this Lease, and any lender or any third party purchasing the Premises at foreclosure sale shall do so subject to this Lease and shall thereafter perform all obligations and be responsible for all liabilities of the LESSOR under the terms of this Lease.

Upon default by LESSOR of any note or deed of trust, COUNTY may, at its option, make all lease payments directly to the lender, and same shall be applied to the payment of any and all delinquent or future installments due under such note or deed of trust.

16. ESTOPPEL CERTIFICATE (6.5 S)

COUNTY agrees that the County Executive Officer shall furnish from time to time upon receipt of a written request from LESSOR or the holder of any deed of trust or mortgage covering the Premises or any interest of LESSOR therein, COUNTY's standard form Estoppel Certificate containing information as to the current status of the Lease. The Estoppel Certificate shall be approved by the Chief Real Estate Officer, and County Counsel.

17. DEFAULTS AND REMEDIES (6.8 S)

The occurrence of any of the following shall constitute an event of default:

- Failure to pay any installment of any monetary amount due and payable hereunder;

- Failure to perform any obligation, agreement or covenant under this Lease.

In the event of any non-monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any non-monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach and LESSOR shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

In the event of any monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach, and LESSOR shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

18. DEBT LIMIT (6.9 S)

LESSOR acknowledges and agrees that the obligation of the COUNTY to pay rent under this Lease is contingent upon the availability of COUNTY funds which are appropriated or allocated by the COUNTY's Board of Supervisors for the payment of rent hereunder. In this regard, in the event that this Lease is terminated due to an uncured default of the COUNTY hereunder, LESSOR may declare all rent payments to the end of COUNTY's current fiscal year to be due, including any delinquent rent from prior budget years. In no event shall LESSOR be entitled to a remedy of acceleration of the total rent payments due over the term of the Lease. The Parties acknowledge and agree that the limitations set forth above are required by Article 16, section 18, of the California Constitution. LESSOR acknowledges and agrees that said Article 16, section 18, of the California Constitution supersedes any law, rule, regulation or statute, which conflicts with the provisions of this paragraph. Notwithstanding the foregoing, LESSOR may have other rights or civil remedies to seek relief due to the COUNTY's default under the Lease. Such rights or remedies may include a right to continue the COUNTY's right of possession under the Lease and sue for the rent as it becomes past due.

19. LABOR CODE COMPLIANCE (6.10 S)

Attachment F

LESSOR acknowledges and agrees that all improvements or modifications required to be performed as a condition precedent to the commencement of the term of this Lease or any such future improvements or modifications performed by LESSOR at the request of COUNTY shall be governed by, and performed in accordance with, the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (Sections 1770, et seq.). These provisions are applicable to improvements or modifications costing more than $1,000.

Pursuant to the provisions of Section 1773 of the Labor Code of the State of California, the Orange County Board of Supervisors has obtained the general prevailing rate of per diem wages and the general prevailing rate for holiday and overtime work in the locality applicable to this Lease for each craft, classification, or type of workman needed to execute the aforesaid improvements or modifications from the Director of the State Department of Industrial Relations. Copies of said prevailing wage rates may be obtained from the State of California, Department of Industrial Relations, or the County Executive Officer.

LESSOR hereby agrees to pay or cause its contractors and/or subcontractors to pay said prevailing wage rates at all times for all improvements or modifications to be completed for COUNTY within the premises, and LESSOR herein agrees that LESSOR shall post, or cause to be posted, a copy of the most current, applicable prevailing wage rates at the site where the improvements or modifications are performed.

Prior to commencement of any improvements or modifications, LESSOR shall provide the County Executive Officer with the applicable certified payroll records for all workers that will be assigned to the improvements or modifications. Said payroll records shall contain, but not be limited to, the complete name, address, telephone number, social security number, job classification, and prevailing wage rate for each worker. LESSOR shall provide, the County Executive Officer bi-weekly updated, certified payroll records for all workers that include, but not be limited to, the weekly hours worked, prevailing hourly wage rates, and total wages paid.

If LESSOR neglects, fails, or refuses to provide said payroll records to the County Executive Officer, such occurrence shall constitute an event of default of this lease and COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, COUNTY may deduct future rent payable to LESSOR by COUNTY as a penalty for such non-compliance of paying prevailing wage, which rent deduction would be COUNTY's estimate, in its sole discretion, or such prevailing wage rates not paid by LESSOR.

Except as expressly set forth in this Lease, nothing herein is intended to grant authority for LESSOR to perform improvements or modifications on space currently leased by COUNTY or for which COUNTY has entered into a lease or lease amendment.

Clause 20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S) is hereby deleted from the Lease.

~~**20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S)**~~

~~In order to comply with child support enforcement requirements of the County of Orange, within thirty (30) days after COUNTY's execution of this Lease agreement, LESSOR agrees to furnish the County Executive Officer, COUNTY's standard form, *Child Support Enforcement Certification Requirements*, which includes the following information:~~

~~A. In the case where LESSOR is doing business as an individual, LESSOR's name, date of birth, Social Security number, and residence address;~~

~~B. In the case where LESSOR is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;~~

~~C. A certification that the LESSOR has fully complied with all applicable federal and state reporting requirements regarding its employees; and~~

~~D. A certification that the LESSOR has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.~~

~~Failure of LESSOR to timely submit the data and/or certifications required above or to comply with all federal and state reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Lease. Failure to cure such breach within sixty (60) calendar days of notice from the County Executive Officer shall constitute grounds for termination of this Lease.~~

~~Notwithstanding any other provisions of this Lease, LESSOR shall be given an opportunity to cure as follows:~~

~~A. A notice of any claimed failure to comply shall be given to LESSOR, in writing, by personal delivery, or facsimile transmission, from the County Executive Officer. The written notice shall state the specific data or certification required, the specific federal or state reporting requirements for child support enforcement that has not been complied with or the specific Wage and Earnings Assignment Order and Notice of Assignment that has not been complied with; and~~

~~B. LESSOR shall have sixty (60) days from the actual receipt of the written notice to cure the failure to comply specified in the notice, provided that LESSOR's performance to cure within sixty (60) days is not hindered, impaired or prevented by federal, state or local agencies. If the claimed failure as set forth in the written notice is failure to perform an act by a certain time, the failure of performance of said certain act by said certain time shall be deemed cured for purposes of this Lease if it is timely performed in accordance with the provisions of this paragraph.~~

~~It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.~~

~~21.~~20. RIGHT TO WORK AND MINIMUM WAGE LAWS (6.13 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LESSOR shall require its employees that directly or indirectly service the Premises or terms and conditions of this Lease, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LESSOR shall also require and verify that its contractors or any other persons servicing the Premises or terms and conditions of this Lease, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LESSOR shall pay no less than the greater of the Federal or California minimum wage to all its employees that directly or indirectly service the Premises, in any manner whatsoever. LESSOR shall require and verify that all its contractors or other persons servicing the Premises on behalf of the LESSOR also pay their employees no less than the greater of the Federal or California minimum wage.

LESSOR shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the Premises or terms and conditions of this Lease.

Notwithstanding the minimum wage requirements provided for in this clause, LESSOR, where applicable, shall comply with the prevailing wage and related requirements, as provided for in the Clause entitled LABOR CODE COMPLIANCE of this Lease.

~~22.~~21. **AUTHORITY (N)**

The Parties to this Lease represent and warrant that this Lease has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

Clause 23. NOTICES (8.1 S) is hereby deleted in its entirety from the Lease and replaced with the following:

~~23.~~22. **NOTICES (8.1 S)**

All notices given pursuant to this Lease shall be in writing (unless otherwise specified herein), addressed as set forth below or as either Party may hereafter designate by notice and shall be deemed delivered (a) upon personal delivery (which shall include delivery by a courier or overnight delivery service), or (b) delivery by e-mail transmission (provided that a copy of such notice is concurrently sent by one of the other methods of service) but only if sent during COUNTY Working Hours, or otherwise on the next business day, or (c) seventy-two (72) hours after deposit in the United States Mail.

TO: LESSOR

Charles Manh and Anh Manh
Manh Family Trust
8990 Westminster Blvd., Second Floor
Westminster, CA 92683
E-mail: CharlieManh@ Hotmail.com

TO: COUNTY

County of Orange
Social Services Agency
500 N. State College Boulevard, 6th Floor
Orange, CA 92868
Attn: Director, Administrative Services
Phone: (714) 541- 7712
E-mail: An.Tran@ssa.ocgov.com

With a copy to:

County Executive Office
333 W. Santa Ana Boulevard, 3rd Floor

Santa Ana, CA 92701
Attention: Chief Real Estate Officer
Phone: (714) 834-3046
E-mail: Scott.Mayer@ocgov.com"

~~All written notices pursuant to this Lease shall be addressed as set forth below or as either party may hereafter designate by written notice and shall be deemed delivered upon personal delivery, delivery by facsimile machine, or seventy-two (72) hours after deposit in the United States Mail.~~

~~TO: LESSOR~~
~~Charles H. Manh and Anh Manh~~
~~Manh Family Trust~~
~~8990 Westminster Blvd., Second Floor~~
~~Westminster, CA 92683~~

~~TO: COUNTY~~
~~County of Orange~~
~~333 Santa Ana Blvd., 3rd Floor~~
~~Santa Ana, CA 92701~~
~~Attention: Scott Mayer, Chief Real Estate Officer~~
~~Email: Scott.Mayer@ocgov.com~~
~~Phone: (714) 834-3046~~

~~24.~~23. ATTACHMENTS (8.2 S)

This Lease includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
   A. Description - Premises
   B. Plot Plan - Premises
   C. Plans and Specifications
   D. Janitorial Specifications
   E. Subordination, Attornment, and Non-Disturbance Agreement

25. MISCELLANEOUS (N)

COUNTY may remove and dispose, and in a manner best suited for such removal and disposition, of any item(s) of furniture ("**Furniture Items**") off the Premises, which is (are) personal property of the LESSOR, as COUNTY deems appropriate or is of no use for COUNTY. LESSOR hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of property

arising from, growing out of or in any way connected with or related to the removal and disposition of the Furniture Items except claims arising from the concurrent active negligence of COUNTY, its officers, agents, and employees.

D. Clause 26. OPTION TO EXTEND TERM (2.3 N) is hereby added to the Lease:

"Clause 26. OPTION TO EXTEND TERM (2.3 N)

COUNTY's Chief Real Estate Officer or designee, shall have the option to extend the term of this Lease for one (1) four (4) year period (**"Extension Period"**) beyond June 30, 2021, which shall be memorialized in an amendment to the Lease executed by the Chief Real Estate Officer, on the same terms and conditions of this Lease except for (a) the base rent ("**Extension Option Base Rent**"), which shall be negotiated at the time of the option as set forth below and shall not result in a base rent higher than fair market value at the time of the extension option, and (b) the base year for operating expenses, which will be reset to the calendar year prior to the year in which the option is exercised. The Extension Period shall not contain an option for COUNTY to terminate the Lease during the term of the Extension Period. COUNTY shall give to LESSOR written notice of its intent to exercise its option to extend the term of this Lease for one (1) four (4) year period no sooner than twelve (12) months or later than four (4) months prior to the Lease termination date.

Subject to other provisions contained in this Lease, COUNTY shall accept the Premises during the Extension Period in the Premises' "as-is, where-is" condition. The Extension Option Base Rent shall be defined as Fair Market Rental Rate, defined and determined as set forth below in this Clause.

Following COUNTY's notice to LESSOR of its intent to extend the Lease for the Extension Period, COUNTY and LESSOR shall work in good faith and with commercially diligent and good faith efforts for sixty (60) days (the **"Initial Negotiation Period"**) in an effort to agree upon the Fair Market Rental Rate. When the Parties agree that negotiations are concluded, or by the expiration of the Initial Negotiation Period, LESSOR will provide COUNTY written notification of either the agreed upon Fair Market Rental Rate or LESSOR's last best offer (the **"Last Best Offer"**).

In the event that within or at the expiration of the Initial Negotiation Period COUNTY and LESSOR cannot agree upon the Fair Market Rental Rate, COUNTY and LESSOR by the end of the following thirty (30) days (the "**Second Negotiation Period**") shall attempt to determine the Fair Market Rental Rate by surveying and compiling rents for Class A office building properties similar in character, condition and quality to the subject property and located within a five (5) mile radius of the Building (**"Qualified Buildings"**), using industry standard sources and databases which contain lease information, lease comps, building specifications and space availabilities. The "**Fair Market Rental Rate**" shall be determined as follows: LESSOR and COUNTY shall independently survey Qualified Buildings that (i) contain at least 5,000 rentable square feet; (ii) offer a similar quantity of parking as the subject property; (iii) are otherwise similar in quality and function as the subject property; and (iv)

which have either entered into an arms-length transaction with an unaffiliated tenant of at least 2,000 rentable square feet within the past twelve (12) months or which have at least 5,000 rentable square feet of space available for lease (collectively, the "**Criteria**"). LESSOR and COUNTY shall each submit a list of up to five (5) Qualified Buildings. The two lists shall be consolidated into one master list. In the event of a discrepancy involving the same Qualified Building, COUNTY and LESSOR shall use best efforts to reconcile the difference. If either the highest or lowest quoted rates deviate by more than ten percent (10%) from the next closest rate, that building will be eliminated from the final master list (**"Final Master List"**). The per square foot rental rate ("**Rental Rate**") from each building shall be the monthly full service gross base rent per rentable square foot received or quoted by each Qualified Building, the Rental Rate shall exclude rent abatement concessions, but such Rental Rate shall include market tenant improvement allowances for renewing tenants, taking into account the cost to LESSOR to make periodic improvements to the Premises as provided in this Lease. The Rental Rate shall be compiled to the Final Master List and shall be summed and the summation divided by the number of Qualified Buildings (less any omitted Qualified Buildings) as follows:

Total Rental Rate of Considered Bldgs.÷ Number of Considered Bldgs. = Fair Market Rental Rate

The Extension Option Base Rent for the Option Period will be calculated as follows:

Extension Option Base Rent = Fair Market Rental Rate

In no event shall the Extension Option Base Rent for the Option Period be greater than LESSOR's Last Best Offer and the final determination will be binding on both Parties. There shall be no abatement of rent or Tenant Improvements, unless the Parties agree to such terms; the Extension Option Base Rent shall increase by three percent (3%) per annum during the Extension Period; and no other terms of the Lease shall change. COUNTY and LESSOR agree to then enter into a Lease amendment to consummate the transaction within a reasonable time period following determination of the Extension Option Base Rent, with time being of the essence."

E. The INSURANCE Clause is hereby deleted in its entirety from the Lease and replaced with the following:

"**27. INSURANCE**

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance written on ISO form CP 00 10 10 12, or a substitute form providing coverage at least as broad, with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures

owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees by the insurance company issuing said policy or policies. LESSOR shall provide the County of Orange with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

f. An Additional Insured endorsement using ISO form CG 20 26 04 13 or a from at least as broad naming the ***County of Orange, its elected and appointed officials, officers, agents and employees*** as an additional insured, or provide blanket coverage which will state, ***AS REQUIRED BY WRITTEN AGREEMENT***;

g. A primary and non-contributory endorsement using ISO form CG 20 01 04 13, or a form at least as broad evidencing that the Lessor's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing;

h. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.

i. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence with a Two Million Dollars ($2,000,000) aggregate; and

j. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

Attachment F

F. Wherever a conflict in the terms or conditions of this Third Amendment and the Lease as previously amended by the First Amendment and Second Amendment exists, the terms and conditions of this Third Amendment shall prevail. In all other respects, the terms and conditions of the Lease, as previously amended and not specifically changed by this Third Amendment, shall remain in full force and effect.

//

IN WITNESS WHEREOF, the parties have executed this Lease the day and year first above written.

LESSOR

CHARLES H. MANH and ANH MANH,
Co-Trustees of the MANH FAMILY TRUST, dated August 15, 2006

By: _____ May ___, 2016
CHARLES H. MANH, Co-Trustee

By: _____ May ___, 2016
ANH MANH, Co-Trustee

APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By_____
Deputy County Counsel

RECOMMENDED FOR APPROVAL:

Social Service Agency

BY: _____
Carol Wiseman, Deputy Director

County Executive Office

~~**COUNTY**~~

~~COUNTY OF ORANGE~~
~~Chief Real Estate Officer~~

_____
~~By: Scott D. Mayer Per Ordinance No. 15-009 of the Board of Supervisors and Minute Order dated June 9, 2015~~

COUNTY

COUNTY OF ORANGE

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Attachment F

BY: _____
Gail Dennis, Administrative Manager
Real Estate Services

_____
Chairwoman of the Board of Supervisors
Orange County, California

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRWOMAN OF THE BOARD PER GC § 25103, RESO. 79-1535

Attest:

_____
ROBIN STIELER
Clerk of the Board of Supervisors of
Orange County, California

GENERAL CONDITIONS (9.1-9.17 S)

1. LEASE ORGANIZATION (9.1 S)

The various headings in this Lease, the numbers thereof, and the organization of the Lease into separate sections and paragraphs are for purposes of convenience only and shall not be considered otherwise.

2. INSPECTION (9.2 N)

LESSOR or his authorized representative shall have the right at all reasonable times and upon reasonable advance notice to COUNTY, which authorization shall not be unreasonably withheld, to inspect the Premises to determine, if COUNTY is complying with all the provisions of this Lease.

3. SUCCESSORS IN INTEREST (9.3 S)

Unless otherwise provided in this Lease, the terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators, and assigns of all the parties hereto, all of whom shall be jointly and severally liable hereunder.

4. DESTRUCTION OF OR DAMAGE TO PREMISES (9.4 S)

"Partial Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is less than 25% of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

"Total Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is 25% or more of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

In the event of a Partial Destruction of the Premises, LESSOR shall immediately pursue completion of all repairs necessary to restore the Premises to the condition which existed immediately prior to said Partial Destruction. Said restoration work (including any demolition required) shall be completed by LESSOR, at LESSOR's sole cost, within sixty (60) days of the occurrence of said Partial Destruction or within an extended time frame as may be authorized, in writing, by COUNTY. The Partial Destruction of the Premises shall in no way render this Lease and/or any option to purchase null and void; however, rent payable by COUNTY under the Lease shall be abated in proportion to the extent COUNTY's use and occupancy of the Premises is adversely affected by said Partial Destruction, demolition, or repair work

required thereby. Should LESSOR fail to complete necessary repairs, for any reason, within sixty (60) days, or other time frame as may be authorized by COUNTY, COUNTY may, at COUNTY's sole option, terminate the Lease or complete necessary repair work and deduct the cost thereof, including labor, materials, and overhead from any rent thereafter payable.

In the event of Total Destruction of the Premises or the Premises being legally declared unsafe or unfit for occupancy, this Lease and/or any option shall in no way be rendered null and void and LESSOR shall immediately instigate action to rebuild or make repairs, as necessary, to restore the Premises (including replacement of all tenant improvements) to the condition which existed immediately prior to the destruction. All rent payable by COUNTY shall be abated until complete restoration of the Premises is accepted by COUNTY. In the event LESSOR refuses to diligently pursue or is unable to restore the Premises to an occupiable condition (including replacement of all tenant improvements) within 180 days of the occurrence of said destruction or within an extended time frame as may be authorized, in writing, by COUNTY, COUNTY may, at COUNTY's sole option, terminate this Lease or complete the restoration and deduct the entire cost thereof, including labor, materials, and overhead from any rent payable thereafter.

Further, LESSOR, at COUNTY's request, shall provide a suitable, COUNTY-approved temporary facility ("**Facility**") for COUNTY's use during the restoration period for the Premises. The Facility may be leased, at market rate, under a short term lease, for which the COUNTY will reimburse LESSOR the cost thereof, on a monthly basis.

5. AMENDMENT (9.5 S)

This Lease sets forth the entire agreement between LESSOR and COUNTY and any modification must be in the form of a written amendment.

6. PARTIAL INVALIDITY (9.6 S)

If any term, covenant, condition, or provision of this Lease is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

7. CIRCUMSTANCES WHICH EXCUSE PERFORMANCE (9.7 S)

If either Party hereto shall be delayed or prevented from the performance of any act required hereunder by reason of acts of God, performance of such act shall be excused for the period of the delay; and the period for the performance of any such act shall be extended for a period equivalent to the period of such

delay. Financial inability shall not be considered a circumstance excusing performance under this Lease.

8. WAIVER OF RIGHTS (9.9 S)

The failure of LESSOR or COUNTY to insist upon strict performance of any of the terms, conditions, and covenants in this Lease shall not be deemed a waiver of any right or remedy that LESSOR or COUNTY may have, and shall not be deemed a waiver of any right or remedy for a subsequent breach or default of the terms, conditions, and covenants herein contained.

9. HOLDING OVER (9.10 S)

In the event COUNTY shall continue in possession of the Premises after the term of this Lease, such possession shall not be considered a renewal of this Lease but a tenancy from month to month and shall be governed by the conditions and covenants contained in this Lease.

10. HAZARDOUS MATERIALS (9.11 S)

LESSOR warrants that the Premises is free and clear of all hazardous materials or substances.

11. EARTHQUAKE SAFETY (9.12 N)

LESSOR is informed and believes that the Premises is not in violation of any applicable seismic safety regulations and building codes.

12. QUIET ENJOYMENT (9.13 S)

LESSOR agrees that, subject to the terms, covenants and conditions of this Lease, COUNTY may, upon observing and complying with all terms, covenants and conditions of this Lease, peaceably and quietly occupy the Premises.

13. WAIVER OF JURY TRIAL (9.15 S)

Each Party acknowledges that it is aware of and has had the advice of Counsel of its choice with respect to its rights to trial by jury, and each party, for itself and its successors and assigns, does hereby expressly and knowingly waive and release all such rights to trial by jury in any action, proceeding or counterclaim brought by any party hereto against the other (and/or against its officers, directors, employees, agents, or subsidiary or affiliated entities) on or with regard to any matters whatsoever arising out of or in any way

connected with this agreement and/or any claim of injury or damage.

14. GOVERNING LAW AND VENUE. (9.16 S)

This agreement has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this agreement, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394.

15. TIME (9.17 S)

Time is of the essence of this Lease.

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EXHIBIT A

DESCRIPTION OF PREMISES (10.1 N)

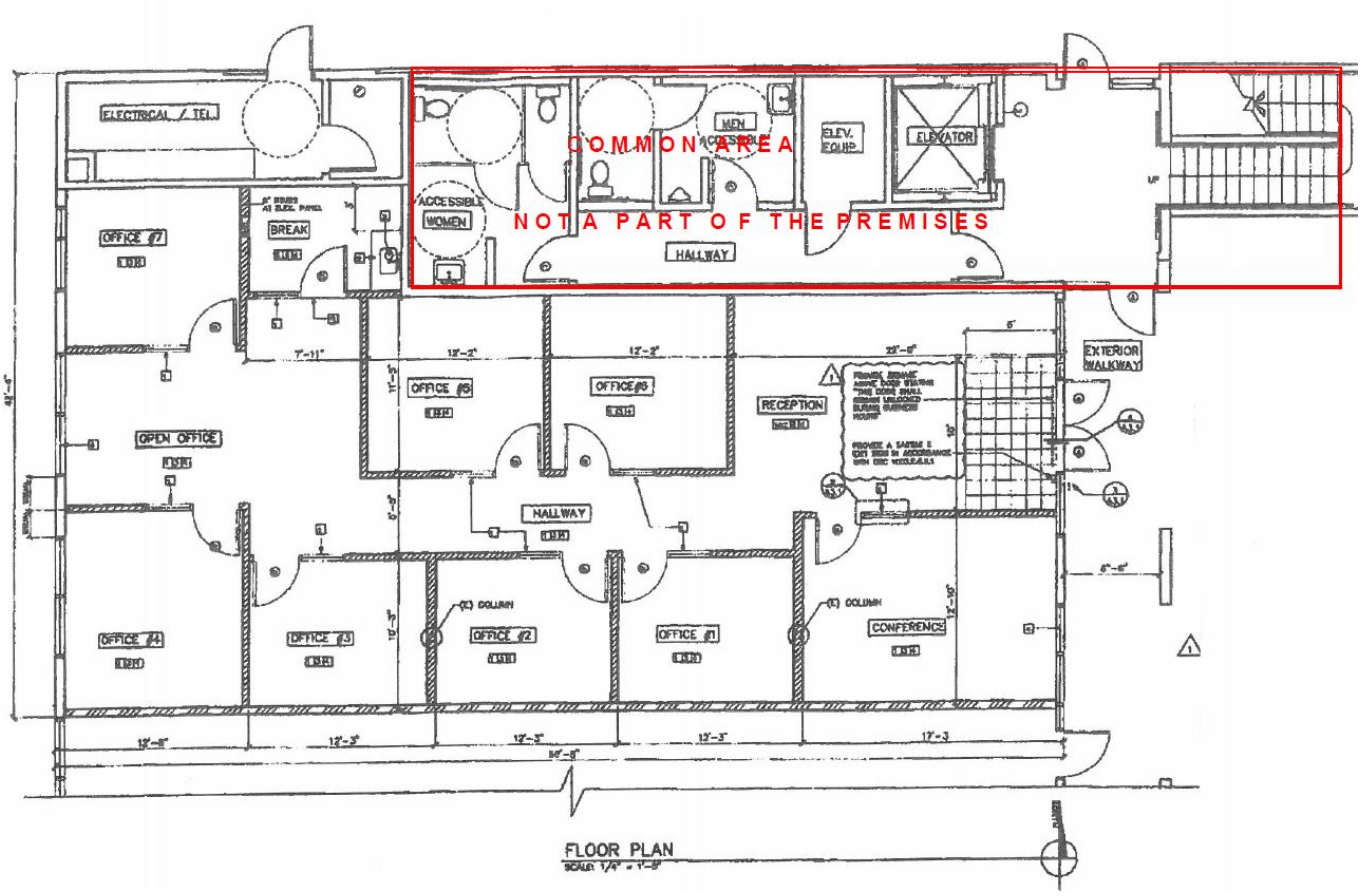
PROJECT: Community Customer Service Annex

All the Premises shown as the floor plan marked Exhibit B, attached hereto and made a part hereof, being a portion of the first floor of that certain two (2) story building located at 15496 Magnolia Street, Suite 111, in the City of Westminster, County of Orange, State of California, together with non-exclusive use of common area restrooms and thirteen (13) parking spaces in the parking areas shown on Exhibit B.

NOT TO BE RECORDED

EXHIBIT B
FLOOR PLAN OF PREMISES

15496 MAGNOLIA STREET, SUITE 111,
WESTMINSTER, CA



Gross Leasable Area: 2,120 Square Feet

EXHIBIT C

PERFORMANCE SPECIFICATIONS (10.3N) LESSOR shall perform the following Work prior to the Commencement Date of this Lease and according to the Tenant Improvement Performance Specifications that follow:

Specific locations to be identified by COUNTY prior to lease execution

1. Repair or replace door closer.
2. Replace stained ceiling tiles.
3. Repair or replace door closer.
4. Remove any signage from previous tenant that exists inside or outside of the Premises
5. Re-key front door and any internal door locks.
6. Provide the security code for existing alarm system.
7. Deliver the Premises with all electrical, plumbing and HVAC systems in proper working order.
8. Repair or replace any HVAC components resulting from findings of COUNTY's inspection of the HVAC system.

1. HEAT, VENT & AIR CONDITION ("HVAC")

A. Heating & air conditioning equipment shall have the capability of maintaining all occupied indoor areas at the room temperatures shown when outdoor temperatures are as follows:

OUTDOORS	*MAINTAIN INDOORS*
Summer – 95° Dry Bulb	78° Dry Bulb at a maximum range of 40% to 60% Relative humidity
Winter – 35° Dry Bulb	68° Dry Bulb

B. All HVAC controls pertinent to the Premises are to be located within the Premises.

C. All HVAC thermostats shall be concealed by a clear plastic tamper proof lock box.

2. ELECTRICAL & COMMUNICATIONS

A. Provide and install fluorescent lighting at all interior spaces that meet code and provide the following minimum lighting intensities at desk level:

LOCATION	*MINIMUM FOOT CANDLES:*
General Offices/Utility Rooms	60
Public Areas	30
General Corridors	20
LOCATION	*MINIMUM FOOT CANDLES:*
Other interior areas	I.E.S. Recommended Levels
Parking Lot	1

B. All Lighting controls pertinent to the Premises shall be located within the Premises.

COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT ("ADA")

LESSOR shall assure that the Premises and Property are in compliance with current standards of the Americans with Disabilities Act for ingress and egress to the Premises and Property.

EXHIBIT D

JANITORIALSPECIFICATIONS (10.4 N)

It is the intent of this Exhibit to provide general guidelines for minimum janitorial service. Any absence of a specific janitorial service from this Exhibit does not relieve LESSOR of the obligation to provide such service should it become necessary.

Janitorial service as required in the clause entitled (REPAIR, MAINTENANCE AND JANITORIAL SERVICE) of this Lease, shall be inclusive of, but not limited to, the services as detailed below:

RESTROOMS

A. **NIGHTLY**:

1. Clean and damp-mop floors;
2. Wash all mirrors, bright work and enameled surfaces;
3. Wash and sanitize all basins, bowls, urinals, and toilet seats;
4. Dust, clean, and wash where necessary, all partitions, tile walls, dispensers, and receptacles;
5. Empty and sanitize all receptacles and sanitary napkin disposals;
6. Provide materials and fill all toilet tissue, towel, seat cover, sanitary napkin, and soap dispensers.

B. **MONTHLY**:

1. Machine strip restroom floors and apply finish/sealer where applicable;
2. Wash all partitions, tile walls, and enamel surfaces;
3. Vacuum all louvers, vents, and dust light fixtures.

MISCELLANEOUS SERVICES

1. Maintain building common/shared areas, corridors, and other public areas in a clean condition;
2. Surface parking lot is to be cleaned on a monthly or more frequent basis;
3. All interior and exterior windows of the building are to be cleaned quarterly.

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EXHIBIT E

SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT

THIS IS A SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT, made _____, 20__, by and between the County of Orange ("COUNTY") and _____ ("LENDER").

A. By lease dated _____, ("Lease"), _____ ("LESSOR") leased to COUNTY and COUNTY leased from LESSOR those certain Premises described as: _____.

B. LENDER is the holder or about to become the holder of a mortgage or Deed of Trust ("Note") which constitutes or will constitute a lien against the Premises leased by COUNTY pursuant to the aforesaid Lease.

C. LENDER has requested that _____ execute a Subordination, Attornment and Non-Disturbance Agreement in accordance with the terms of the Lease.

NOW, THEREFORE, the parties hereto do hereby agree as follows:

1. Subject to the terms and conditions of the Lease, all rights of COUNTY thereunder are or shall become subordinate to the Note and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions thereof.

2. In the event that LENDER succeeds to the interest of LESSOR under the Lease, by reason of foreclosure of the Note, by other proceedings brought to enforce any rights of LENDER under the Note, by deed in lieu of foreclosure, or by any other method, COUNTY shall promptly attorn to LENDER under all of the terms, covenants, and conditions of the Lease for the balance of the then-current term (and any extension or renewals thereof which may be effective in accordance with any option therefore contained in the Lease), with the same force and effect as if LENDER were the Lessor under the Lease. So long as COUNTY is not in default under the Lease, LENDER or its successors in interest shall not disturb the interests of COUNTY under said Lease, but shall allow said interests to continue in full force and effect for the balance of the then-current term and any extension available to COUNTY which may be provided in accordance with the Lease. Said attornment shall be effective and self-operative immediately upon LENDER'S succession to the interest of LESSOR under the Lease.

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3. This agreement may not be modified orally or in any manner other than by written agreement signed by the parties hereto or their respective successors or assigns. All of the terms, covenants, and conditions herein shall run with the land and shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

COUNTY:

COUNTY OF ORANGE

By:_____

County Chief Real Estate Officer

Name:_____

LENDER:

By:

Print

Title:

APPROVAL AS TO FORM:
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By:_____

Deputy County Counsel

Date:_____

Attachment F

GA1213-237-2
SSA/CalOptima
15496 Magnolia Avenue
Westminster, CA 92683

SECOND AMENDMENT TO LICENSE

THIS SECOND AMENDMENT TO LICENSE AGREEMENT ("**Second Amendment**") is made and entered into on June 14, 2021, by and between CALOPTIMA, a public agency (hereinafter referred to as "**Licensee**") and the COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as "**County**"), without regard to number and gender. County and Licensee may sometimes hereinafter be referred to individually as "**Party**" or jointly as "**Parties**."

RECITALS

I. Pursuant to a lease dated July 1, 2016, County leases that certain real property located at 15496 Magnolia in the City of Westminster, State of California ("**Lease**"), commonly known as the Orange County Community Service Center Annex ("**OCCSCA**"), for County's Social Services Agency ("**SSA**").

II. Pursuant to that certain license agreement dated August 4, 2016, ("**License**"), the County licenses to Licensee for its use a total of three hundred and sixty-two (362) rentable square feet ("**RSF**"), of the OCCSCA ("**Licensed Area**"), more particularly shown in Exhibit B, attached to the License. The License sets out the terms and conditions of Licensee's use of the License Area to provide health related services workshops and information regarding Medi-Cal benefits ("**Services**").

III. The License was amended on August 23, 2017 ("**First Amendment**") to extend the term for four years, which will expire on June 30, 2021.

IV. The Parties have agreed to amend the License to extend the term for one additional year through June 30, 2022, for Licensee to continue to provide the Services.

NOW, THEREFORE, in consideration of the Recitals, above, which are incorporated herein by this reference, the Parties do herby agree to amend the License as of the date entered above, ("**Effective Date**") as follows:

A. Clause 2 TERM (AMLC-3.1 N) is hereby deleted from the License in its entirety and the following clause is substituted:

"**2. TERM (AMLC-3.1 N)**

The License commenced on August 4, 2016, and shall terminate on June 30, 2022, unless otherwise terminated consistent with Clause 3 (TERMINATION) of this License."

B. Clause 7 LICENSE FEE (AMLC-6.1 S) is hereby deleted from the License in its entirety and the following clause is substituted:

"**7. LICENSE FEE (AMLC-6.1 S)**

Licensee agrees to pay County consistent with the following schedule:

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Commencing	Monthly License Fee
July 1, 2017	$1,560.98
July 1, 2018	$1,607.81
July 1, 2019	$1,656.04
July 1, 2020	$1,705.72
July 1, 2021	$1,705.72

The Monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the Monthly License Fee begins or terminates on some day other than the first day or last day of the month, the Monthly License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month."

C. Wherever a conflict in the terms or conditions of this Second Amendment, First Amendment and the original License exists, the terms and conditions of this Second Amendment shall prevail. In all other respects, the terms and conditions of the License and First Amendment not specifically changed by this Second Amendment shall remain in full force and effect.

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IN WITNESS WHEREOF, the Parties have executed this Second Amendment the day and year first above written.

APPROVED AS TO FORM:

Office of County Counsel
Orange County, California

By _____
Deputy County Counsel

Date: 6-4-2021

LICENSEE

CalOptima
CEO, CalOptima

***By _____ DocuSigned by: Richard Sanchez 234AD421BDEC4D9...
Richard Sanchez 05/27/2021

Print Name: _____

***By _____

Print Name: _____

RECOMMENDED FOR APPROVAL

SOCIAL SERVICES AGENCY

By _____
Dorthe Lee, Director of Administration

COUNTY

COUNTY OF ORANGE

By _____
Thomas A. Miller, Chief Real Estate Officer
County Executive Office
Per Resolution No. 19-002 of the Board of Supervisors and Minute Order dated January 8, 2019.

Date: June 14, 2021

COUNTY EXECUTIVE OFFICE

By _____
Steven K. Miller, Administrative Manager
Real Estate Services

*** Pursuant to the requirements of California Corporations Code section 313, one of the following two methods must be used by a corporation when it enters into a contract with the County: Two people must sign the document. One of them must be the chairman of the board, the president or any vice president. The other must be the secretary, any assistant secretary, the chief financial officer or any assistant treasurer. One corporate officer may sign the document, providing that written evidence of the officer's authority to bind the corporation with only his or her signature must be provided. This evidence would ideally be a corporate resolution.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

5. Authorize Modification to and Extension of the Contract with Miller Geer & Associates for External Communications Support Services

Contacts

Michael Hunn, Chief Executive Officer (Interim), 657-900-1481
Rachel Selleck, Executive Director, Public Affairs, 657-900-1096

Recommended Action

Authorize the Chief Executive Officer (CEO) to modify the Scope of Work of CalOptima's current contract with Miller Geer & Associates, extend the term of the contract, effective February 1, 2022, through June 30, 2024, and increase the fixed monthly consulting services rate to $15,000, and add up to an additional $5,000 in monthly pass-through costs for allied services.

Background

On October 7, 2021, the Board approved a contract and funding for CalOptima's engagement of Miller Geer & Associates to support the agency's response to urgent and emerging communications issues stemming from regulatory audits, leadership transitions, new program implementations and pandemic response. Miller Geer has secured considerable media coverage that contributed positively to CalOptima's reputation. The contract was initially approved by the Board at a fixed monthly rate of $12,000 through June 30, 2022.

Discussion

Staff requests Board approval to modify the scope of work and payment provisions of the Miller Geer & Associates contract to support CalOptima's ability to strengthen strategic communications, media relations and brand enhancement effective February 1, 2022. Miller Geer's consulting services may be supplemented with allied services, including but not limited to video production, graphic design, translation and related services, which will be billed separately as pass-through costs. The proposed term of the modified contract would extend through June 30, 2024. Miller Geer's services aim to promote brand recognition and awareness of CalOptima's community impact as well as mitigate any adverse impact to the agency's reputation. The Communications Department will direct Miller Geer's work and ensure it complements and extends efforts by internal staff, with an overall goal of elevating CalOptima's recognition as a health care leader in Orange County.

Fiscal Impact

The estimated additional cost to the FY 2021-22 Operating Budget is $8,000 per month or $40,000 for the remaining five-months of the fiscal year. Sufficient funding to cover these expenses is included as part of the Communication – Professional Fees budget under the CalOptima Fiscal Year 2021-22 Operating Budget. Management plans to include the increased contracted payment provisions in future operating budgets.

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Rationale for Recommendation

Approving the modified and extended Miller Geer & Associates contract is intended to strengthen CalOptima's communications capabilities and support enhanced recognition of the agency in the community.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Contract No. 22-10159 Between CalOptima and Miller Geer and Associates
3. Draft Amendment No. 1 to Contract No. 22-10159

Board Action(s)

None.

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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Attachment to the February 3, 2022, Board of Directors Meeting – Agenda 5

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Miller Geer & Associates	3532 Katella Ave., Unit 110	Los Alamitos	CA	90720

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DocuSign Envelope ID: 8049684A-F795-4748-B111-6A1CCA770746

CONTRACT NO. 22-10159
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
MILLER GEER AND ASSOCIATES
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of August 1st, 2021, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Miller Geer and Associates, a Corporation, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Crisis Communication Support Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

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

D. CONTRACTOR desires to perform these services for CalOptima; and

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

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be

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changed without the prior written consent of CalOptima.

Name	Function/Title
Jay Geer	President
James Chisum	Vice President
Nancy Franklin	Special Consultant

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft,

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damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

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3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

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

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

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

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts

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(including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

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6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

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10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree

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to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

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12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

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14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR is not entitled to any reimbursement for travel, meals, accommodations, or other similar expenses under this Contract.

15. Term. This Contract shall commence on August 1st, 2021, and shall continue in full force and effect through 06/30/2022, unless earlier terminated as provided in this Contract.

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16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

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

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

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

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

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any

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information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

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

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare

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and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

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20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

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

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or

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other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

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

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

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

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

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Miller Geer and Associates	CalOptima
3532 Katella Ave, UNIT 110	505 City Parkway West
Los Alamitos, CA 90720	Orange, CA 92868
Attention: James Chisum	Attention: Ryan Prest

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

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be

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entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

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

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

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

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

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of

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this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

41.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

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41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

42.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

42.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

42.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative

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agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

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IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10159.

Miller Geer and Associates	CalOptima
By: Jay D. Geer	By: DocuSigned by: Richard Sanchez 234AD421BDEC4D9...
Print Name: JAY D. GEER	Print Name: Richard Sanchez
Title: President	Title: CEO, CalOptima
Date: 10/20/2021	Date: 10/29/2021
By: James Chisum	By:
Print Name: JAMES CHISUM	Print Name:
Title: Vice President	Title:
Date: 10/20/21	Date:

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

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Exhibit A
SCOPE OF WORK

I. OBJECTIVE

CalOptima has determined that the potential gravity of negative coverage warrants the engagement of external crisis communication services. CalOptima shall engage CONTRACTOR's expertise to strengthen CalOptima's response to urgent and emerging issues that may garner negative media attention, and to mitigate any adverse impact to the CalOptima brand or reputation.

II. SCOPE OF WORK

The CONTRACTOR shall bring specific background in the area of crisis response and provide the following services:

1. PRODUCTS/SERVICES

CONTRACTOR shall utilize their extensive contacts within both the general media as well as the specialized health care industry media, and deep experience in managing those relationship to the benefit of CalOptima. The CONTRACTOR shall provide services and deliverables outline below upon CalOptima request, based on the timing of the urgent issue to be addressed. The products/services shall be delivered electronically to the Director, Communications.

2. SUPPLIER'S RESPONSIBILITIES

The CONTRACTOR's responsibilities shall include but not be limited to"

- timely response to all parties, including CalOptima staff, Board members and consultants.
- be available for meetings and conference calls as needed.
- adhere to all mutually agreed upon deadlines for deliverables in 4. and provide revisions as requested.
- provide a monthly summary with each invoice that recounts key activities in the month and the impact of the work.

3. CALOPTIMA'S RESPONSIBILITIES

- CalOptima shall set deadlines for deliverables and approve all materials developed as outlined in 4.
- CalOptima shall conduct all work with the vendor in a virtual environment, and the vendor shall deliver work product electronically.
- CalOptima shall provide access to executives as needed by the vendor to gather information or arrange media response.

4. DELIVERABLES

a. Given the nature of crisis communications, CalOptima requires the products/services to be delivered within 24 hours or sooner after the assignment is made. CalOptima includes the following deliverables within this scope of work:
    a. Crisis Communications Plan (specific to each engagement/crisis): An outline of the issue, key messages, audiences to reach and tactics to use.
    b. Company Statements: Official statements that will serve as a comment for the media.
    c. Talking Points: Message points that can be used by leaders and key stakeholders, including affected providers.
    d. Ongoing Support: Communications counsel as CalOptima works through crisis cycle, from initial announcement to resolution/closure.

5. PERFORMANCE GUARANTIES/MEASURES

a. Performance shall be measured based on adherence to deadlines and responsiveness to changing needs during the crisis period. Some measure of flexibility shall be required based on the nature of the crisis; therefore, performance shall be measured in terms of ability to adapt to situations and supply appropriate, beneficial response. Monitoring of performance shall be conducted by Executive Director, Public Affairs and Director, Communications. The penalty for lack of performance may result in Contract termination as outlined in the Contract.

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Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10159; detailed description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Twelve Thousand Hundred Dollars ($12,000.00) per month equaling One Hundred Thirty-Two Thousand Dollars ($132,000.00), 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. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

E. Should the Contract terminate early and that termination land mid-month, the final month shall be prorated at 1/30th of the monthly retainer per day equaling Four Hundred Dollars ($400) per day.

F. Should CalOptima or CONTRACTOR feel that the level of support for the Services listed in Exhibit A has grown or reduced significantly, both parties agree to negotiate in good faith any price adjustment needed. For such price adjustment to be valid, an Amendment signed by both parties shall be executed prior to incurring any additional fees.

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Exhibit B-1

Not applicable for this Contract

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Exhibit C

Not applicable for this Contract

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Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

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

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

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

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: Gay D. Geer Date: 10/20/2021

Print Name: GAY D. GEER

Title: PRESIDENT

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Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

M. Lee Geer & Associates Inc.	Jay D. Geer
Name of Contractor	Printed Name of Person Signing for Contractor
22-10159	Jay D. Geer
Contract/Grant Number	Signature of Person Signing for Contractor
10/22/2024	President
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

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DocuSign Envelope ID: 8049684A-F795-4748-B111-6A1CCA770746

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	☐a. bid/offer/application ☐b. initial award ☐c. post-award	☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity:	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

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Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

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Exhibit F

Not applicable for this Contract

DocuSign Envelope ID: 8049684A-F795-4748-B111-6A1CCA770746

Exhibit G

Not applicable for this Contract

DocuSign Envelope ID: 8049684A-F795-4748-B111-6A1CCA770746

Exhibit H

Not applicable for this Contract

DocuSign Envelope ID: 8049684A-F795-4748-B111-6A1CCA770746

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Miller Geer & Associates Inc

Business Entity Type: California corporation
(Sole Proprietorship, Partnership, LLC, California Corporation, etc.)

Business Address: 3532 Katella Ave. Suite 110

City: Los Alamitos State: Ca Zip: 90720

Business Phone: 562 493-6023 Email: : JAye millergeer.com

President: JAy Geer Contact Person: JAy Geer

Person(s) Signing Contract & Title: : JAy Geer

*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 %
JAy Geer	President 100%

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Jay D. Geer
Authorized Signature

10/20/2021
Date

JAy D. Geer, President
Name and Title

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Exhibit J

Not applicable for this Contract

DocuSign Envelope ID: 8049684A-F795-4748-B111-6A1CCA770746

Exhibit K

Not applicable for this Contract

DocuSign Envelope ID: 8049684A-F795-4748-B111-6A1CCA770746

Exhibit L

Not applicable for this Contract

DocuSign Envelope ID: 2482601A-CEA7-4EB4-B428-7B156E2CC4C6

AMENDMENT NO. 1 TO CONTRACT NO. 22-10159
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba CALOPTIMA
AND
MILLER GEER AND ASSOCIATES
(CONTRACTOR)

AMENDMENT NO. 1 to this CONTRACT is entered into as of the date last signed below, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 22-10159 on 10/20/2021 for Crisis Communication Support Services.

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both parties.

C. The Parties now desire to modify the scope of work, payment terms, and extend the Contact.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Exhibit A, Scope of Work in the Contract is hereby deleted in its entirety and replaced with Attachment A to this Amendment No. 1.

2. Exhibit B, Payment, Section D is hereby deleted in its entirety and replaced with the following:
   2.1. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Fifteen Thousand Hundred Dollars ($15,000.00) per month, including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.
   2.2. Not included in the monthly fee above, CONTRACTOR shall be able to, with prior written approval from CalOptima's Director, Communications or Executive Director, Public Affairs, pass-through fees for services needed to fulfill the Scope of Work, including but not limited to graphic design, video production, document translation and clipping services. These pass-through fees will be paid on an as-used basis and are capped at Five Thousand Dollars ($5,000.00) per month.
   2.3. For February 2022, the new monthly rate listed above in Section 2.1 will be prorated as follows:
      2.3.1. February 1, 2022, through and including the date last signed below will be calculated at 1/28 x $12,000, per day.
      2.3.2. The day after this Amendment No. 1 is signed through February 28, 2022, will be calculated at 1/28 x $15,000, per day.
      2.3.3. Sections 3.1 and 3.2 will be added together to have the prorated funds for February 2022.
      2.3.4. All months after February will be billed at the rate above in Section 2.1.

3. Exhibit B, Payment, Section E is hereby deleted in its entirety and replaced with the following.
   3.1. Should the Contract terminate early and that termination land mid-month, the final month shall be prorated at 1/30th of the monthly retainer per day equaling Five Hundred Dollars ($500) per day.

4. The Term of the Contract, as specified in Paragraph 15 of the Contract, is hereby extended two additional years through 6/30/2024, unless earlier terminated as provided in the Contract..

5. **No Other Changes.** This Amendment No 1 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this

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Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 1 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

6. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

7. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 1 to Contract 22-10159 on the day and year last shown below.

MILLER GEER AND ASSOCIATES	CALOPTIMA
Signature: DocuSigned by: Jay Geer 96FCACF15010401...	Signature: _____
Name: Jay Geer	Name: _____
Title: President	Title: _____
Date: 1/21/2022	Date: _____
Signature: DocuSigned by: James Chisum D302696F1C9E4FD...	Signature: _____
Name: James Chisum	Name: _____
Title: Vice President	Title: _____
Date: 1/21/2022	Date: _____

DocuSign Envelope ID: 2482601A-CEA7-4EB4-B428-7B156E2CC4C6

SCOPE OF WORK

I. OBJECTIVE

Based on internal and external factors, CalOptima's programs are experiencing significant change and growth, and strategic communications needs are shifting in response to this transition as well. CONTRACTOR shall provide expertise in communications, media relations and related areas to strengthen CalOptima's response to urgent and/or emerging issues, position the agency for greater brand recognition and build the agency's reputation for health care leadership locally and nationwide.

II. SCOPE OF WORK

The CONTRACTOR shall apply specific expertise in strategic communications, media relations, messaging and engagement to provide the following services:

1. PRODUCTS/SERVICES

CONTRACTOR shall utilize their health care industry knowledge and extensive contacts within both the general media as well as the specialized health care industry media for the benefit of CalOptima's brand and reputation. The CONTRACTOR shall provide services and deliverables outline below upon CalOptima request. The products/services shall be delivered electronically to the Director, Communications.

2. SUPPLIER'S RESPONSIBILITIES

The CONTRACTOR's responsibilities shall include but not be limited to

- timely response to all parties, including CalOptima staff, Board members and consultants.
- be available for meetings and conference calls as needed.
- adhere to all mutually agreed upon deadlines for deliverables in 4. and provide revisions as requested.
- provide a monthly summary with each invoice that recounts key activities in the month and the impact of the work.

3. CALOPTIMA'S RESPONSIBILITIES

- CalOptima shall set deadlines for deliverables and approve all materials developed as outlined in 4.
- CalOptima shall conduct all work with the CONTRACTOR in a virtual environment, and the CONTRACTOR shall deliver work product electronically.
- CalOptima shall provide access to executives as needed by the CONTRACTOR to gather information or arrange media response.

4. DELIVERABLES

a. Strategic Communications: CONTRACTOR to provide counsel, communications plans and message development upon identification of key issues, including but not limited to new programs or transitions; member, provider and community awareness; stakeholder outreach and engagement; and crisis communications and response.
b. Media Relations: CONTRACTOR to conduct proactive outreach and engagement with local, state and national media to cultivate awareness of CalOptima and strengthen positioning as a health care leader.
c. Communications Research: CONTRACTOR to provide research and/or survey services when a need for external stakeholder and community data is identified to drive communications success.
d. Communications Support: CONTRACTOR to supply supplemental communications support upon request with services such as video production, graphic design, website content, social media content, language translations and related services.

5. PERFORMANCE GUARANTIES/MEASURES

a. Performance shall be measured based on adherence to deadlines and responsiveness to changing needs. Some measure of flexibility shall be required based on the nature of the communications environment; therefore, performance shall be measured in terms of ability to adapt to situations and supply appropriate, beneficial response. Monitoring of performance shall be conducted by Executive Director, Public Affairs and Director, Communications. The penalty for lack of performance may result in Contract termination as outlined in the Contract.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
6. Authorize Actions Related to American Family Housing Casa Paloma Care Coordination

Contacts
Dr. Richard Helmer, Interim Medical Director, (657) 933-1823
Marie Jeannis, Executive Director Quality & Population Health Management, (714) 423-2891

Recommended Action(s)
Authorize the Chief Executive Officer (CEO) with the assistance of Legal Counsel, to enter into a Memorandum of Understanding (MOU) with American Family Housing (AFH) Casa Paloma to provide Medi-Cal supportive services for CalOptima members and participate in information exchange activities to ensure care coordination.

Background
In August 2019, the CalOptima Board of Directors authorized and CalOptima issued a letter of commitment to AFH Casa Paloma LP, an affiliate of American Family Housing (AFH), in connection with its grant application under the Department of Housing and Community Development Housing for a Healthy California (HHC) Program. Under this letter of commitment, CalOptima agreed to enter a Memorandum of Understanding (MOU) to coordinate care for CalOptima Medi-Cal members who had experienced chronic homelessness and were high-cost healthcare utilizers prior to residing at Casa Paloma permanent supportive housing (PSH) units funded under HHC. In December 2020, the Board authorized CalOptima to issue an updated Letter of Commitment and American Family Housing received the HHC grant funding for Casa Paloma.

American Family Housing anticipates that all or nearly all residents at Casa Paloma are likely to be CalOptima Medi-Cal members when they become residents. Casa Paloma will have 71 total housing units, 48 permanent supportive housing, and 34 funded under HHC. Casa Paloma is projected to be completed and ready for occupancy by June 2022.

In February 2019, the Board authorized establishment of the CalOptima Homeless Response Team (HRT) to coordinate the scheduling and dispatch of the Clinical Field Team (CFT). The CFT provides on-call urgent care services for members and individuals experiencing homelessness in Orange County, regardless of payor source. The HRT serves as a liaison with public agencies, homeless service providers, members' assigned health network and primary care provider to support care coordination for CalOptima members experiencing homelessness. The existing HRT processes will be leveraged to support the coordination of care process with AFH.

Discussion
CalOptima and AFH began meeting in 2019 to educate each other about their respective programs and collaborate on the development of HHC letters of commitment, MOU, and care coordination protocols. The MOU between CalOptima and AFH will provide covered services for CalOptima Medi-Cal members residing at the Casa Paloma property. These covered services will include care coordination, primary,

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preventive and specialty care, and non-medical transportation. CalOptima HRT will provide both on-site and remote care coordination to individuals with complex medical needs, experiencing homelessness residing at the Casa Paloma property. Additionally, the HRT will ensure navigation support to connect AFH and members with their assigned health networks, providers, and covered services.

Fiscal Impact

There is no additional fiscal impact to CalOptima's participation in the HHC program. Services provided under the program will be limited to medically necessary covered services for CalOptima enrolled Medi-Cal members. To the extent there is any fiscal impact due to increases in required resources, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation

CalOptima and American Family Housing share common goals of improving care and health outcomes for residents of Orange County, including members experiencing homelessness. Staff believes that the partnership with AFH as described in the MOU will be beneficial for residents who are CalOptima members and would reduce the risk of return to homelessness, enhance efficiencies and avoid duplication of services between CalOptima, AFH, and other service providers.

Concurrence

To be completed by Legal Department. Click to add feedback for the proposed recommended action.

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action December 3, 2020, COBAR: Consider a New Letter of Commitment for Medi-Cal Supportive Services with a Grant Award to American Family under the Housing for a Healthy California Program
3. Previous Board Action April 4, 2019: Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. December 4, 2020, Letter of Commitment for Housing for a Healthy California Program
5. Draft American Family Housing Memorandum of Understanding

Board Action(s)

If multiple Board actions were previously taken for this recommended action, please list them in the table below. If not, please remove entire section, including table.

Board Meeting Dates	Action	Term	Not to Exceed Amount
12/3/2020	Authorize a new letter of commitment for Medi-Cal supportive services in connection with a grant award to American Family Housing under the Housing for a Healthy California Program	N/A	N/A

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Board Meeting Dates	Action	Term	Not to Exceed Amount
8/1/2019	Authorized letters of commitment related to Medi-Cal Supportive Services participation in the Housing for Healthy California Program	N/A	N/A
4/4/2019	Authorized actions related to the delivery of care for homeless CalOptima members including startup cost for the CalOptima Homeless Response Team	5 years	$1.2 million/year (totaling $6 million)
2/22/2019	Authorized eight unbudgeted positions and related costs to establish the CalOptima Homeless Response Team	1 year	$1.2 million

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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Attachment to the February 3, 2022 Board of Directors Meeting – Agenda Item 6

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
American Family Housing	15161 Jackson Street	Midway City	CA	92655
AFH Casa Paloma LP	15161 Jackson Street	Midway City	CA	92655

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 3, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

14. Consider a New Letter of Commitment for Medi-Cal Supportive Services in Connection with a Grant Award to American Family Housing under the Housing for a Healthy California Program

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Candice Gomez, Executive Director, Program Implementation, (714) 246-8849
Debra Kegel, Director, Strategic Development, (714) 347-5763

Recommended Actions

Authorize the Chief Executive Officer to issue a new letter of commitment for Medi-Cal supportive services in connection with a grant award to American Family Housing under the Housing for a Healthy California Program

Background

In September 2017, AB 74 was signed into law authorizing the California Department of Housing and Community Development to develop the Housing for a Healthy California (HHC) Program to create supportive housing opportunities through competitive grants to counties and developers. The goal of the HHC Program is to reduce the financial burden of emergency room visits, inpatient care and nursing home stays, and the use of the corrections systems and law enforcement resources as the point of entry for health care for the target population.

The target population for the HHC Program includes individuals who are:

- Chronically homeless, or homeless and high-cost health care users upon initial eligibility;
- Medi-Cal beneficiaries
- Eligible for Supplemental Security Income;
- Eligible to receive services under a program providing services promoting housing stability; and,
- Likely to improve their health conditions with supportive housing.

American Family Housing (AFH) submitted an application for development and operations of the Casa Paloma property, a 49-unit complex in Orange County, including 24 permanent supportive housing units. The application included a Supportive Services Plan (the Plan), which identified AFH as the Lead Service Provider (LSP) with overall responsibility for provision of the supportive services and for implementation of the Plan. The LSP may provide services directly or through agreement with other agencies. The application also included budget and staffing information for service delivery, including from subcontractors; HHC permits the budget to include the value of in-kind services that might be provided, for example, by a Medi-Cal Managed Care Plan, including Health Homes Programs (HHP).

On August 1, 2019, the CalOptima Board of Directors approved issuance of a letter of commitment in connection with the AFH application for participation in the HHC Program.
The letter issued by CalOptima included the in-kind value of services that CalOptima would provide for its members. The letter stated that CalOptima's responsibility would include services that are provided under its contracts with the Department of Health Care Services (DHCS), such as providing access to

primary, preventive and specialty care for all tenants who are CalOptima members, including enhanced services for HHP-enrolled members. AFH and CalOptima contemplated a Memorandum of Understanding (MOU) describing how AFH and CalOptima would coordinate services for CalOptima members residing at Casa Paloma and participating in the HHC Program; AFH had initially advised that the MOU would be required in early 2021.

Discussion

Since that time, AFH has advised that funding has been secured for the development of the Casa Paloma property that is now expected to include 69 affordable housing units, of which 34 will be permanent supportive housing units funded under HHC. Additionally, AFH has advised that the MOU will not be required until late 2022 when the property is ready for occupancy.

In lieu of the MOU, and in light of the increased number of HHC permanent supportive housing units, AFH has asked for CalOptima to issue a new letter of commitment that will supersede the previous letter. The request is that the updated letter will:

- Adjust the projected annual estimate of in-kind support for Medi-Cal Covered Services and HHP services to eligible Medi-Cal members;
- Reiterate that CalOptima's obligations will include only services required under its DHCS contracts; and,
- Reflect that services will be limited to CalOptima Medi-Cal members, including those in HHP (or successor program).

CalOptima staff will return to the Board at a future meeting to seek authority to enter into the MOU, if needed.

Fiscal Impact

Management does not anticipate an additional fiscal impact for the proposed participation in the HHC Program. Services provided under the HHC Program will be limited to medically necessary covered services for CalOptima enrolled Medi-Cal members. To the extent that there is any fiscal impact due to increases in required resources, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation

CalOptima and AFH share common goals of improving care and health outcomes for residents of Orange County, including members experiencing homelessness. Providing a new letter of commitment will support AFH as it continues development of the property intended to increase opportunities for CalOptima members who are chronically homeless or high-cost health utilizers, including those who may be eligible or enrolled in HHP.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated August 1, 2019, Consider Medi-Cal Supportive Services Participation in the Housing for Healthy California Program

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

Attachment to the December 3, 2020 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
American Family Housing	15161 Jackson Street	Midway City	CA	92655
AFH Casa Paloma LP	15161 Jackson Street	Midway City	CA	92655

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Medi-Cal Supportive Services Participation in the Housing for Healthy California Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. With respect to the Grant application submitted by AFH Casa Paloma LP and by other developer applicants under Article I of the Department of Housing and Community Development Housing for Healthy California (HHC) Program, authorize the Chief Executive Officer (CEO) to provide such applicants whose target populations include CalOptima Medi-Cal Members with a letter of commitment for Medi-Cal supportive services in conjunction with their proposed participation for the program;
2. With respect to the Grant application submitted by the Orange County Health Care Agency (HCA) under Article II of the Department of Housing and Community Development Housing for Healthy California (HHC) Program:
   A. Authorize the CEO to provide HCA with a letter of commitment for Medi-Cal supportive services participation for the program; and,
   B. Authorize the CEO, with the assistance of Legal Counsel, to enter into a Memorandum of Understanding (MOU) with HCA to coordinate Supportive Services and information exchange activities.

Rev. 8/1/19

Background

In September 2017, AB 74 was signed into law authorizing the California Department of Housing and Community Development (HCD) to develop the Housing for Healthy California (HHC) Program to create supportive housing opportunities through competitive grants to counties and developers. The goal of the HHC Program is to reduce the financial burden of emergency room visits, inpatient care and nursing home stays and use of corrections systems and law enforcement resources as the point of health care for people who are chronically homeless or are homeless and high-cost health care users.

On May 13, 2019, HCD released final guidance and Notice of Funding Availability (NOFA), including application requirements for two funding opportunities under:

- Article I: for property owners or developers for operating reserve grants and capital loans using National Housing Trust Fund allocations; and

- Article II: for counties to acquire, newly construct, or reconstruct and rehabilitate homes, as well as for rental subsidies and rental assistance for existing and new supportive

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housing opportunities. For this purpose, "county" means a county, city and county or a city collaborating with a county to secure services funding.

The target population to be served under both Articles I and II is a person who is:

- Chronically homeless or is homeless and high-cost health care users upon initial eligibility;
- A Medi-Cal beneficiary;
- Eligible for Supplemental Security Income;
- Eligible to receive services under a program providing services promoting housing stability; and,
- Likely to improve his or her health conditions with Supportive housing.

A Supportive Services Plan (the Plan) must be submitted with applications under Articles I and II. The Plan describes the supportive services provided for those eligible for HHC Program and identifies the Lead Service Provider (LSP) with overall responsibility for provision of the supportive services and for implementation of the Plan. Supportive Services are defined as social, health, educational, income support and employment services and benefits, coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits. The LSP may provide services directly or through agreement with other agencies. The LSP must have at least three or more years of experience serving members in the target population, including comprehensive case management in supportive housing.

The application under Article I must also include a Memorandum of Understanding (MOU) or commitment letter from the Lead Service Provider or county department to make available to the project's HHC tenants case management and supportive services from one of the following:

- County's Whole Person Care (WPC) Pilot;
- Health Homes Program (HHP);
- Managed care organization (MCO); or,
- Other community-based health care services.

The Application under Article II requires identified funding sources for providing intensive services promoting housing sustainability including, for example:

- County general funds;
- WPC pilot program funds, to the extent those funds are available, or the WPC program has been renewed;
- HHP;
- MHSA program;
- MCO; or,
- Other County-controlled funding to provide these services to eligible participants.

The application under Articles I and II require budget and staffing information for service delivery, including from subcontractors, which may include in-kind services that might be

provided, for example, by an MCO and HHP programs. The applications are due August 13, 2019.

Discussion

Orange County Community Resources and HCA (jointly the County) have taken a leadership role for planning and supporting development of applications by an owner or developer under Article I, and by HCA under Article II, as well as for Supportive Services Plan development under Article II. Collaboration between CalOptima and County on the HHC Program began in March 2019.

Article I

AFH Casa Paloma LP is expected to submit an application under Article I for development of a 49-unit complex of which will 24 will be supportive housing units (Development). AFH Casa Loma LP has advised that its affiliate, American Family Housing, Inc. a 501(c) (3) organization, will be the LSP for the Development. The application will include the Supportive Services Plan outlining the roles and responsibilities of the LSP, HCA, and CalOptima; CalOptima's responsibility will include services that are required of it under its DHCS contracts, such as providing access to primary, preventive and specialty care for all tenants who are CalOptima members and, for HHP enrolled members, housing navigation services and tenancy support services. Thus, CalOptima's participation will be limited to CalOptima Medi-Cal Members, including those in HHP and to Medi-Cal covered services. AFC Casa Loma LP has requested CalOptima provide a letter of commitment to satisfy the application requirements. CalOptima anticipates that any other applicant under Article I would make a similar request. Additionally, AFS Casa Loma has requested that CalOptima enter into a Memorandum of Understanding (MOU) with its LSP prior to the first tenancy if it is awarded an HHC grant; the first tenancy is not expected until at least 2021. CalOptima staff will return to the Board at a future meeting to seek authority to enter the MOU, if needed.

Article II

The HCA has advised that it intends, subject to Board of Supervisors approval, to submit an application under Article II for funding for housing subsidies for 214 individuals. CalOptima staff and the County have reviewed the application requirements, as well as their respective experience with the target population. They also discussed the HCA led Whole Person Care pilot, under the Department of Health Care Services (DHCS) Medi-Cal 2020 waiver program; discussions included CalOptima's on-going participation in WPC, the current December 31, 2020 waiver expiration date and HCA's planned development of a sustainability plan to continue services following termination of the WPC pilot.

CalOptima staff has shared information about the anticipated implementation of HHP on January 1, 2020, subject to DHCS approval. CalOptima staff and the County have also reviewed the overlapping target populations and services under their various respective programs. It has been noted that some potential tenants may not be CalOptima Medi-Cal members (either initially or during their tenancy), and that many of the specific services (e.g., peer support, recreational and social activities) are not covered services under CalOptima's Medi-Cal Agreement with DHCS,

and some services will be covered only for members enrolled in HHP (e.g., housing navigation and tenancy support services). Thus, CalOptima's participation will be limited to CalOptima Medi-Cal Members, including those in HHP and to Medi-Cal covered services.

CalOptima staff and the County additionally reviewed the application requirements, particularly related scoring based on experience in providing supportive housing services. In order to provide the strongest possible application, HCA is expected to be the LSP under Article II. The application will include the Supportive Services Plan outlining the roles and responsibilities of the LSP and CalOptima. HCA has requested CalOptima provide a letter of commitment to satisfy the application requirements. Additionally, HCA has asked that CalOptima enter into an MOU, should HCA be awarded an HHC grant. Similar to Article I, CalOptima's responsibility will be consistent with its responsibilities under its DHCS Medi-Cal contract.

Fiscal Impact
Management does not anticipate an additional fiscal impact for the proposed participation in the HHC Program. Services provided under the HHC Program will be limited to Covered Services for CalOptima enrolled Medi-Cal Members. To the extent there is any fiscal impact due to increases in required resources, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation
CalOptima, County and American Family Housing share common goals of improving care and health outcomes for residents of Orange County, including members experiencing homelessness. HHC provides increased opportunities for CalOptima members who are chronically homeless or high-cost health utilizers, including those who may be eligible or enrolled in HHP and/or WPC.

Concurrence
Gary Crockett, Chief Counsel

Attachments
California Department of Housing and Community Development Housing for Healthy California Final Guidelines amended May 13, 2019

/s/ Michael Schrader *7/24/2019*
Authorized Signature **Date**

Housing for a Healthy California (Chapter 777, Statutes of 2017)
Final Guidelines Amended

State of California
Gavin Newsom, Governor

Alexis Podesta, Secretary
Business, Consumer Services and Housing Agency

Ben Metcalf, Director
Department of Housing and Community Development

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January 25, 2019
Amended May 13, 2019

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The matters set forth herein are regulatory mandates, and are adopted in accordance with the authorities set forth below:

> Quasi-legislative regulations … have the dignity of statutes … [and]… delegation of legislative authority includes the power to elaborate the meaning of key statutory terms…
>
> *Ramirez v. Yosemite Water Co.*, 20 Cal. 4th 785, 800 (1999)
>
> Any regulations or guidelines that are adopted, amended, or repealed to implement this part shall not be subject to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
>
> Health and Safety Code Section 53598, subdivision (b).

INTRODUCTION

The Housing for a Healthy California (HHC) Program provides funding that allows the California Department of Housing and Community Development (Department) to provide Supportive housing opportunities through grants to Counties for capital and operating assistance, or operating reserve grants and capital loans to developers on a competitive basis. The guidelines for the Program are organized into two Articles as follows:

Article I. National Housing Trust Fund Allocation. This section includes Program definitions and requirements pursuant to the federal National Housing Trust Fund (NHTF) allocations. The Department will allocate these NHTF funds competitively to developers for operating reserve grants and capital loans.

Article II. Building Homes and Jobs Trust Fund Allocation. This section includes Program definitions and requirements pursuant to SB 2 Building Homes and Jobs Act. The Department will utilize a portion of monies collected in calendar year 2018 and deposited into the Building Homes and Jobs Trust Fund for the HHC program. The Department will allocate these funds competitively to counties for acquisition, new construction, reconstruction, rehabilitation, administrative costs, capitalized operating subsidy reserves (COSR), and rental subsidies and rental assistance for existing and new Supportive housing opportunities to assist the HHC program's Target Population.

A Notice of Funding Availability (NOFA) will be released for each Article as funds are available.

Housing for a Healthy California Program Final Guidelines

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Article I. National Housing Trust Fund Allocation

Section 100. Purpose and Scope

(a) In September of 2017, AB 74 was signed into law. This legislation authorizes the California Department of Housing and Community Development (Department) to develop the Housing for a Healthy California (HHC) Program to create Supportive housing for individuals who are recipients of or eligible for health care provided through the California Department of Health Care Services (DHCS) Medi-Cal program. The goal of the HHC program is to reduce the financial burden on local and state resources due to the overutilization of emergency departments, inpatient care, nursing home stays and use of corrections systems and law enforcement resources as the point of health care provision for people who are Chronically homeless or Homeless and a High-cost health user. The Department shall coordinate with the DHCS, consistent with state and federal privacy laws, to match program participant data to Medi-Cal data to identify outcomes among participants as well as changes in health care costs and utilization associated with housing and services provided under HHC.

(b) AB 74 directs the Department to utilize federal National Housing Trust Fund (NHTF) allocations for years 2018 - 2021 for the HHC program. Starting in August 2018, and for the next three years, the Department must submit a federal NHTF allocation plan that aligns with federal NHTF and AB 74 requirements. The Department will allocate these NHTF funds competitively to developers for operating reserve grants and capital loans.

In addition to applicable state and federal laws and regulations, these guidelines (hereinafter “Guidelines”) implement, interpret, and make specific the HHC authorized by Part 14.2 (commencing with Section 53590) of Division 31 of the Health and Safety Code.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 101. Definitions

All terms not defined below shall, unless their context suggests otherwise, be interpreted in accordance with the meaning of terms described in Part 14.2 of Division 31 of the Health and Safety Code (commencing with Section 53590).

(a) “Applicant” means an organization, agency, or other entity (including a public housing agency, a for-profit entity, or a nonprofit entity) that is an owner or developer as defined by 24 CFR 93.2.

(b) “Area Median Income” or “AMI” means the most recent applicable county median family income published by the U.S. Department of Housing and Urban Development (HUD).

(c) “Assisted Unit” means a housing unit that is subject to the NHTF rent and/or occupancy restrictions as a result of the financial assistance provided under the program.

(d) “Case Manager” means a social worker or other qualified individual who works with a tenant to offer individualized service planning that is flexible and creative to help the tenant gain housing stability. It includes working in collaboration with the tenant to plan, assess, coordinate, and reassess the tenant’s needs, as well as providing referrals and advocacy, and connecting to community support to meet tenants’ supportive service needs. Services include, but are not limited to: tenancy support services, coordination of medical and behavioral health, and substance use disorder treatment, employment services, life skills training, peer support, and crisis management interventions. Resident service coordinators are not Case Managers.

(e) “Chronically homeless” has the same meaning as in Part 91.5 and 578.3 of Title 24 of the Code of Federal Regulations, except that people who were Chronically homeless before entering an institution would continue to be defined as Chronically homeless before discharge, regardless of length of stay, as those parts read on January 1, 2018.

(f) “Continuum of Care” has the same meaning as 24 CFR Section 578.3.

(g) “Coordinated Entry System” or “CES” means a centralized or coordinated process developed pursuant to 24 CFR Section 578.7(a)(8) designed to coordinate program participant intake, assessment, and referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

(h) “Department” means the California Department of Housing and Community Development.

(i) Development Sponsor or “Sponsor”, as defined in Section 50675.2 of the Health and Safety Code and subdivision (c) of Section 50669 of the Health and Safety Code, means any individual, joint venture, partnership, limited partnership, trust, corporation, cooperative, local public entity, duly constituted governing body of an Indian Reservation or Rancheria, or other legal entity, or any combination thereof, certified by the Department as qualified to own, manage, and rehabilitate a rental housing development. A Development Sponsor may be organized for profit, limited profit or be nonprofit, and includes a limited partnership in which the Development Sponsor or an affiliate of the Development Sponsor is a general partner.

(j) “Distributions” has the same meaning as under 25 CCR Section 8301.

(k) “Extremely Low Income” or “ELI” has the same meaning as in 24 CFR 93.2.

(l) “Federal Housing Trust Fund” has the same meaning as the National Housing Trust Fund (NHTF) established pursuant to the Housing and Economic Recovery Act of 2008 (Public Law 110-289) and implementing federal regulations.

(m)"Fiscal Integrity" means, for any project for any given period of time during the term specified in the Program's regulatory agreement, that the total Operating Income for such project for such period of time, plus funds released pursuant to the Program documents from the project's operating reserve account(s) during such period of time is sufficient to: (1) pay all current Operating Expenses for such project for such period of time; (2) pay all current mandatory debt service (excluding deferred interest) coming due with respect to such project for such period of time; (3) fully fund all reserve accounts established pursuant to the Program documents for such project for such period of time; and (4) pay other costs permitted by the Program documents for such project for such period of time. The ability to pay any or all the permitted annual distributions for a project shall not be considered in determining the Fiscal Integrity of a project.

(n) "HHC" means the Housing for a Healthy California Program administered by the Department.

(o) "High-cost health users" mean people who have had either at least three emergency department visits or one hospital inpatient stay over the last year.

(p) "Homeless" has the same meaning as in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018.

(q) "Housing First" has the same meaning as in Welfare and Institutions Code Section 8255.

(r) "HUD" means the federal U.S. Department of Housing and Urban Development.

(s) "Lead Service Provider" or "LSP" means the organization that has the overall responsibility for the provisions of Supportive Services and implementation of the Supportive Services plan. The LSP may directly provide comprehensive case management services or contract with other agencies that provide services.

(t) "NOFA" means a Notice of Funding Availability.

(u) "Operating Expense" has the same meaning as in 25 CCR Section 8301.

(v) "Operating Income" has the same meaning as in 25 CCR Section 8301.

(w) "Operating Cost Assistance Reserves" has the same meaning as in 24 CFR Section 93.201(e).

(x) "Permanent housing" means a housing unit where the landlord does not limit length of stay in the housing unit, the landlord does not restrict the movements of the tenant, and the tenant has a lease and is subject to the rights and responsibilities of tenancy, pursuant to Chapter 2 (commencing with Section 1940) of Title 5 of Part 4 of Division 3 of the Civil Code.

(y) "Point in Time Count" or "PIT" refers to an annual count of sheltered and unsheltered homeless persons on a single night in January.

(z) “Program” means the Housing for a Healthy California Program.

(aa) “Project Team” consists of the Applicant, the Lead Service Provider, and the property manager.

(bb) “Recipient” means an Applicant who has been awarded NHTF funds and has the same meaning as in 24 CFR 93.2. A Recipient must:

(1) Make acceptable assurances that it will comply with all NHTF requirements during the entire affordability period;

(2) Demonstrate ability and financial capacity to undertake, comply, and manage the eligible activity;

(3) Demonstrate familiarity with requirements of state, federal, and any other housing programs used in conjunction with NHTF funds to ensure compliance; and

(4) Demonstrate experience and capacity to conduct the eligible NHTF activity in question as evidenced by relevant history.

(cc) “Rural Area” has the same meaning as in Section 50199.21 of the California Health and Safety Code.

(dd) “Supportive housing” means housing with no limit on length of stay, that is occupied by the Target Population and that is linked to onsite or offsite services that assist the Supportive housing resident in retaining the housing, improving his/her health status, and maximize his/her ability to live, and when possible, work in the community.

(ee) “Supportive Services” means social, health, educational, income support and employment services and benefits, coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits.

(ff) “Target Population” means a person who is Chronically homeless or is Homeless and a High-cost health user upon initial eligibility, is a Medi-Cal beneficiary, is eligible for Supplemental Security Income, is eligible to receive services under a program providing services promoting housing stability, and is likely to improve his or her health conditions with Supportive housing.

(gg) “TCAC” means California Tax Credit Allocation Committee.

(hh) “UMR” means the Uniform Multifamily Regulations commencing with 25 CCR Section 8300.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53590 and 53595.

Section 102. Minimum Requirements

The Applicant shall comply with the requirements of HHC and all applicable federal and state laws. To be eligible to receive funding, projects must meet all the following minimum requirements:

(a) Eligible Applicants.

(1) Owners or developers that meet the Recipient definition in 24 CFR 93.2.

(2) Applicant with no members of the development team currently federally debarred or suspended.

(b) Financial Feasibility. The project shall meet the requirements of Sections 105 and 106 and must prove Fiscal Integrity.

(c) Experience. Collectively, among the members of the Project Team, all the following minimum experience requirements must be met:

(1) Development, ownership, or operation of at least two permanent Supportive housing projects or at least two affordable rental housing projects in the last five years.

(2) The Lead Service Provider, which may be the county, or a qualified contracted agency, shall have three or more years of experience serving persons who qualify as members of the Target Population and includes comprehensive case management in Supportive housing, and can include scattered site housing.

(3) The property manager shall have three or more years of experience serving persons who qualify as members of the Target Population in Supportive housing.

(4) Experience must be documented through contracts with public agencies, housing owners, or foundations for services provided to at least 10 households at any one time in either housing projects subject to agreements with public agencies restricting rent and occupancy or through tenant-based housing assistance programs. If the Lead Service Provider is not part of the ownership entity, the Applicant must have a written agreement with the Lead Service Provider to implement the Supportive Services plan and submit this agreement along with the application for funding. Only the Lead Service Provider may enter into written agreements for services under the provisions of the Supportive Services plan. All service providers must have a written agreement with the Lead Service Provider prior to commencement of services.

(d) Site Control. The Applicant must have site control of the proposed project that meets the requirements of the UMR 25 CCR Section 8303, which requires the Applicant to have site control of the proposed project property, in the name of the Applicant or an entity controlled by the Applicant. The ownership interest may be demonstrated by fee title, a leasehold interest, an enforceable option to purchase, a disposition and

development agreement, an agreement giving the Applicant exclusive rights to negotiate for acquisition, or a land sales contract. This includes compliance (if applicable) with UMR 25 CCR Section 8316 for a leasehold interest in the property.

(e) Integration. Proposed projects must demonstrate integration of the Target Population with the general public. In order to demonstrate compliance with this requirement, the following conditions must all be met:

(1) Assisted Units must be integrated with other units in the project and not separated onto separate floors or areas of the building;

(2) To promote integration of the Target Population with other project tenants, in projects of greater than 20 units, the Department will fund no more than 49 percent of the project's total units as Assisted Units. This limitation shall not be interpreted to preclude occupancy of any project units by persons with disabilities or restrictions by other funding sources, including but not limited to TCAC, that result in more than 49 percent of the total project units being restricted to the Target Population. It shall also not apply to projects complying with alternative requirements for demonstrating Olmstead compliance adopted by local jurisdictions and approved by the Department;

(3) Applicants must certify that they will facilitate or provide regular community building activities and architectural design features that promote tenant interaction. For example, indoor and outdoor community space within the project, and wide hallways as feasible, depending on the scope of the construction activity; and

(4) The Supportive Services plan and property management plan, submitted with the application, must document policies that promote participation by tenants in community activities and impose no restriction on guests that are not otherwise required by other project funding sources or would not be common in other unsubsidized rental housing in the community.

(f) Article XXXIV. All projects shall comply with Article XXXIV Section 1 of the California Constitution, as clarified by Public Housing Election Implementation Law (H&S Code Section 37000 et seq). Article XXXIV documentation for loans underwritten by the Department shall be subject to review and approval by the Department prior to the execution of the Department's Standard Agreement.

(g) Scattered Site Housing. Projects are permitted to be on scattered sites provided that all of the below conditions are satisfied prior to the closing of the loan. The requirements of this section shall be interpreted in a manner consistent with the requirements of 25 CCR Section 8303(b) pertaining to scattered site housing.

(1) All project sites in the rental housing development must have a single owner and property manager;

(2) All project sites shall be governed by one set of Program documents, which among other things, shall include similar tenant selection criteria, serve similar

tenant populations, and have similar rent and income restrictions;

(3) If the rental housing development has an operating reserve, there shall only be one operating reserve for all sites in the project;

(4) There may be at most one lender with required payments senior to the Department's loan;

(5) There must be a single audit and annual report that covers all project sites;

(6) The Sponsor's obligations under the Department's Program documents must be secured by all project sites, with lien priority relative to local public agency lenders determined in accordance with 25 CCR Section 8315, and use of cash flow available for residual receipts loan payments determined in accordance with 25 CCR Section 8314; and

(7) The Department must be named on insurance policies covering all project sites, with coverage meeting Department requirements.

(h) Environmental Conditions. All project sites must be free from severe adverse environmental conditions, such as the presence of toxic waste that is economically infeasible to remove and that cannot be mitigated. See 24 CFR 93.301(f).

(i) Federal, State and Local Requirements. All Assisted Units and other units of the project must be on a permanent foundation and must meet all applicable federal, state, and local requirements pertaining to rental housing, including, but not limited to, requirements for minimum square footage and requirements related to maintaining the property in a safe and sanitary condition.

(j) Amenities. All project sites must involve a development site that has reasonable accessibility to public transit, public schools, public parks or other public recreational facilities, and is of reasonable proximity to services and amenities for the purposed tenant population as is typically available in that county. The development site must also be within reasonable proximity to employment opportunities available to the tenant population. The development must consider the hours that the services and amenities are available and the frequency, travel time, and cost of transportation to the tenants. The criteria used to establish reasonable accessibility and reasonable proximity are specified in Section 111(h) of the Guidelines.

(k) Stacking Unit-Based Subsidies.

(1) The Department does not allow stacking of multiple Department Development Funding Sources on an HHC Assisted Unit. Capitalized operating subsidy reserves or operating assistance is allowed for all units. The prohibition of subsidy stacking in HHC refers to the use of multiple funding sources on a single HHC-assisted unit. "Department Development Funding Sources" shall mean loan or grant funds awarded for permanent funding of development costs under the following programs:

a. Multifamily Housing Program
b. Supportive Housing Multifamily Housing Program

c. Veterans Housing and Homelessness Prevention Program
d. No Place Like Home Program, including funds awarded either by the Department or an Alternative Process County
e. Affordable Housing and Sustainable Communities Program Affordable Housing
f. Development loan, except for grants for infrastructure, transportation-related amenities and program costs
g. Transit Oriented Development Program rental housing development loan, except for grants for infrastructure
h. Joe Serna, Junior Farmworker Housing Grant Program
i. SB 2 Farmworker Housing Program
j. National Housing Trust Fund Program

(2) As an exception to this Subsection (k)(1), a previously Department-assisted unit is eligible for funding assistance from other Department programs upon re syndication, or 14 years from the Placed in Service date noted on the TCAC form 8609 (Placed in Service Package).

(l) Relocation. The Applicant of any project resulting in displacement of tenants shall be solely responsible for providing the assistance and benefits set forth in this subsection and in applicable federal, state, and local law, whichever is more stringent.

(1) All tenants of a property who are displaced as a direct result of the development of an HHC project shall be entitled to relocation benefits and assistance as provided in 24 CFR 93.352.

(2) The Applicant shall prepare a relocation plan conforming with the provisions of 24 CFR 93.352. For loans underwritten by the Department, the relocation plan or other relocation documentation shall be subject to the review and approval by the Department prior to the beginning of construction.

(m) Applicant must comply with 2 CFR Part 200.

(n) Application shall be on forms made available by the Department. In addition, applications must contain:

(1) A resolution from the Applicant's governing board to apply for NHTF funds for a requested amount that does not exceed the amount authorized.

(2) A memorandum of understanding or commitment letter from either the Lead Services Provider or a county department to make available to the project's HHC tenants case management and Supportive Services from one of the following:
a. County's Whole Person Care Pilot,
b. Health Homes Program,
c. Managed care organization, or
d. Other community-based health care services.

(3) A certification that residents of the housing development will be authorized to own or otherwise maintain one or more common household pets pursuant to the Pet Friendly Housing Act of 2017 (California Health & Safety Code, Section 50466).

(4) An initial plan for providing Supportive Services based on the anticipated needs of the Target Population proposed to be served by the project must meet the requirements outlined in Section 112.

(5) A property management plan that:
   a. Utilizes a low-barrier tenant selection process;
   b. Accepts referrals of those with the highest needs for available housing;
   c. Implements Housing First practices, consistent with the core components set forth in Welfare and Institutions Code Section 8255(b);
   d. Implements policies and practices to prevent evictions and to facilitate the implementation of reasonable accommodation policies;
   e. Implements policies and practices of trauma-informed care and harm reduction to prevent evictions; and
   f. Implements policies and practices that comply with the Violence Against Women Act (Title VI-Safe Homes for Victims of Domestic Violence, Dating Violence, Sexual Assault, and Stalking – Section 601 – 603 and 81 CFR 80724).

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 103. Uses and Terms

(a) NHTF funds will be limited to the eligible uses described in 24 CFR 93.200 and 93.201.

(1) Loans for acquisition and/or new construction.
   a. NHTF loans shall be used in accordance with 24 CFR Part 93 Subpart E.
   b. Proposed projects involving new construction and requiring the demolition of existing residential units are eligible only if the number of bedrooms in the new project is at least equal to the total number of bedrooms in the demolished structures. The new units may exist on separate parcels provided that all parcels are part of the same project and meet the requirements of scattered site housing described in Section 102(g).
   c. The total amount of NHTF assistance shall not exceed the maximum per-unit development subsidy amount established by the Department as stated in the NOFA.
   d. HHC loans shall be secured by the project's real property and improvements and subject only to liens, encumbrances and other matters of record approved by the Department, consistent with 25 CCR Section 8315. Projects with ground leases shall be subject to 25 CCR Section 8316.
   e. HHC assistance provided as post-construction permanent loans shall have an initial term of 55 years or longer to match the period of affordability restrictions under the tax credit program, commencing on the date of recordation of the HHC loan documents.

(2) Grants for project-based operating assistance in the form of a Capitalized Operating Subsidy Reserve (COSR).

The project's COSR will be for at least 15 years to pay for operating costs of an apartment or apartments receiving capital funding to provide Supportive housing to the Target Population.

(b) Maximum per-unit loan amounts for loans underwritten by the Department shall be published annually for each NOFA and determined as follows:

(1) Maximum per-unit loan amounts shall not exceed the total eligible costs required, when considered with other available financing and assistance, in order to:
a. Enable the funds to be used for the eligible uses;
b. Ensure that rents for Assisted Units comply with Program requirements; and
c. Operate in compliance with all other Program requirements.

(2) The capital portion of the loan amount is further limited to the sum of a base amount per Assisted Unit, plus the amount per Assisted Unit required to reduce rents from 30 percent of the 30 percent of AMI level to the actual maximum restricted rent for the Assisted Unit, with loan limits increasing based on the level of affordability provided.

(3) For loan limit calculations, the Department shall include the number of Assisted Units within a rental housing development and the number of bedrooms per Assisted Unit.

(4) For Assisted Units receiving rental assistance under renewable rental subsidy contracts, the loan amount will be based on the most restrictive level of income restriction that will apply following the closing of the program loan.

(5) Initial base amounts for the portion of the loan that does not include a COSR are set pursuant to the Department's Annual Action Plan.

(6) The COSR portion of the loan shall be determined pursuant to the requirements of Section 108.

(7) Beginning January 2020, the amounts in subparagraph (5), above, will be adjusted annually based upon increases in the Consumer Price Index. The maximum per-unit amounts for loans underwritten by the Department shall be updated annually and published in the NOFA.

(c) Recipients shall ensure that all Assisted Units meet all applicable federal and state property standards. Compliance with 24 CFR 93.301(a)(1) and (2) must be maintained for the duration of the affordability period of 55 years, except projects developed on Indian Reservation or Native American lands, which will be for at least 50 years.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 104. Loan Terms

(a) HHC loans shall have the following terms:

(1) They shall bear simple interest at the rate of 3 percent per annum on the unpaid principal balance, unless the Department reduces this rate pursuant to Health and Safety Code Section 50406.7. Interest shall accrue from the date funds are disbursed to, or on behalf of, the borrower.

(2) Pursuant to 24 CFR section 93.204(b)(1), HCD will charge fees to cover the cost of ongoing monitoring and physical inspection of NHTF rental projects during the state period of affordability and as determined in the NOFA.

(3) Except for the required monitoring fee payment, and if the borrower is not in default, the Department shall permit the deferral of accrued interest for the term of the loan.

(4) The Department may require a third-party tax professional to verify the necessity for reducing the interest rate below 3 percent, the cost of which shall be borne by the Sponsor.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 105. Occupancy and Income Requirements

(a) Household income shall be determined in accordance with the rules in 24 CFR 93.151. At the time of move-in, the household income shall not exceed the established Extremely Low Income (ELI) limits or families with incomes at or below the poverty line (whichever is greater) pursuant to 24 CFR 93.250(a). Income levels shall be expressed in 5 percent increments as a percentage of AMI. The income limits are posted on the Department's website. Assisted units will be restricted per the income limits set forth in the Project Regulatory Agreement.

(b) The Recipient shall maintain documentation of tenant-income eligibility and how they meet the requirements for the Target Population the following ways, as applicable:

(1) Documentation of enrollment in or eligibility for Medi-Cal benefits.

(2) Documentation of a person's status as Chronically homeless could be captured through any of the following:
   a. A client's entry and exits documented in a Homeless Management Information System;
   b. An outreach worker or Case Manager's written observations; or
   c. A client's self-report of episodes of homeless and disability status. Such reports must be done in accordance with procedures established through the local Coordinated Entry System or other procedures established by

the county for determining whether a person qualifies as Homeless and High-cost health user or Chronically homeless.

(3) Documentation of a person's status as a High-cost health user could be captured through any of the following:
   a. Discharge summaries; or
   b. An outreach worker's, case manager's or local County's health department written observations.

(c) Occupancy requirements shall apply for the full term of the regulatory period.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 106. Rent Limits

(a) Assisted Unit rent will be restricted in accordance with the NHTF rent and income limits in 24 CFR 93.302.

(1) ELI tenants. The rent plus utilities of an ELI tenant shall not exceed the greater of 30 percent of the federal poverty line or 30 percent of the income of a family whose annual income equals 30 percent of the median income for the area, as determined by HUD, with adjustments for the number of bedrooms in the unit. HUD will publish the NHTF rent limits on an annual basis. Rents will be further restricted in accordance with Rent and income limits submitted by the Sponsor in its application for the Program loan, approved by the Department, and set forth in the Regulatory Agreement.

(b) The income of each tenant must be determined initially in accordance with 24 CFR 93.151. In addition, in each year during the period of affordability (up to 55 years), the project owner must reexamine each tenant's annual income in accordance with one of the options in 24 CFR 93.151(c) selected by the Recipient and as identified in the tenant selection plan.

(c) Over-income tenants. Assisted Units continue to qualify as affordable housing despite a temporary noncompliance caused by increases in the incomes of existing tenants if actions satisfactory to HUD are being taken to ensure that all vacancies are filled in accordance with 24 CFR Part 93.302(g) until the noncompliance is corrected.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 107. Underwriting Standards

(a) In analyzing feasibility, the Department shall follow the underwriting requirements of its UMRs commencing with 25 CCR Section 8300 and/or federal NHTF regulations, including the following:

(1) 25 CCR Section 8303 (Site Control Requirements and Scattered Site Projects);

(2) 24 CFR 93.201(e) (Operating Cost Assistance and Operating Cost Assistance Reserves);

(3) 25 CCR Section 8309 (Replacement Reserves);

(4) 25 CCR Section 8310 (Underwriting Standards) and 24 CFR 93.300(b). The more strict requirements shall apply;

(5) 25 CCR Section 8311 (Limits on Development Costs);

(6) 25 CCR Section 8312 (Developer Fee);

(7) 25 CCR Section 8314 (Use of Operating Cash Flow), and 24 CFR Part 93. The stricter requirements shall apply; and

(8) 25 CCR Section 8315 (Subordination Policy).

(b) Where there is a difference between the provisions of the UMRs and these Guidelines, the provisions of these Guidelines shall prevail.

(c) Notwithstanding the above, residential stabilized vacancy rates for Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market data or other evidence.

(d) In addition to the operating reserve required by 25 CCR 8308, a Sponsor may establish a COSR for the Assisted Units meeting the requirements of Section 108.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 108. Capitalized Operating Subsidy Reserves

NHTF grant funds may be used to pay for Capitalized Operating Subsidy Reserves (COSR) with the following conditions:

(a) For projects, not more than 100 percent of the total per-unit amount for capital determined pursuant to Section 103 may be provided per unit for a COSR to address project operating deficits attributable to the Assisted Units.

(b) The operating reserves shall be sized to cover anticipated operating deficits attributable to the Assisted Units for a minimum of 15 years. The total amount of each project's operating reserves will be determined based upon the individual project underwriting performed by the Department pursuant to the requirements of these Guidelines.

(c) In determining how to size each project's COSR, the Department shall consider individual project factors such as: the maximum percentage of Assisted Units it will assist; the anticipated project vacancy rates; the anticipated percentage of Assisted

Units that will have other operating or rental subsidy and the term of that operating or rental subsidy contract, and anticipated tenant incomes.

(d) The following standard assumptions will be used for establishing the total amount of the project COSR. The Department may modify these assumptions as necessary to maintain project feasibility or extend the term of the COSR.

(1) All Assisted Units, other than the proportionate share of the manager's unit, shall be counted in calculating the amount of the COSR. An Assisted Unit receiving other rental assistance may receive assistance from the COSR.

(2) The stabilized residential vacancy rate for the Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market or other evidence.

(e) Notwithstanding the above, in order to sustain the availability of the operating reserves for a minimum of 15 years, distributions from the COSR shall be subject to: The Department may not disburse more than 5 percent of the total COSR to a project per year, except that in any given year where the operating deficit attributable to the Assisted Units exceeds this amount, the Department may, in its sole discretion, increase the disbursement to up to 7 percent of the total COSR, in accordance with the operating reserves limits and applicable review processes;

(f) Asset management and partnership management fees and deferred developer fees shall only be paid in accordance with the requirements of Section 107.

(g) In accordance to 24 CFR 93.201(e)(1), Operating Expenses that are eligible to be paid from the COSR include:

(1) Insurance

(2) Utilities

(3) Real property taxes

(4) Maintenance

(5) Scheduled payments to a reserve for replacement of major systems

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 109. Award Limits

(a) The maximum loan limit per Applicant is $20,000,000. The limit on the amount that can be used for the COSR will be one third of the total loan amount, in accordance with 24 CFR 93.200(a)(1).

(b) NHTF funding will be made available to all jurisdictions in California. Pursuant to the Department's Annual Plan, the Department will set-aside at least 20 percent of the funding for projects located in Rural Areas. In the event no projects target the 20 percent set-aside for projects located in Rural Areas, funds will be distributed according to the distribution methods of 24 CFR 91.320(d) and (k).

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 110. Application Process

(a) Contingent upon an annual federal NHTF allocation, the Department shall issue a competitive NOFA for NHTF funding that specifies, among other things, the amount of project funds available, any restrictions on uses of funds, general terms and conditions of funding applications, minimum requirements, timeframe for submittal of applications, application requirements, and rating metrics. Application requirements include, but are not limited to, the following:

(1) Identification of Applicants;

(2) Information on the proposed project;

(3) Adequate information to determine Applicant's eligibility;

(4) Adequate information to determine project's eligibility;

(5) Certification of compliance with federal and state requirements;

(6) Resolution by the governing board authorizing the application and execution of all documents;

(7) Adequate information to determine Applicant's experience;

(8) Site control;

(9) Compliance with the state's policy on Housing First;

(10) Project readiness to proceed;

(11) A Supportive Services plan, including staff-to-client ratio (1:20);

(12) Commitment of services funding; and

(13) Adequate information to determine the project's feasibility.

(b) Applications shall be on forms made available by the Department.

(c) Applications shall be evaluated for compliance with the minimum requirements set forth in Section 102 and will be rated and ranked in accordance with the criteria outlined in Section 111. Applicants that do not meet the minimum requirements will

be rejected and will not be rated. Applicants will be subject to the appeal process as detailed in the NOFA.

(d) If requesting a COSR, the Applicant must comply with the requirements in Section 108 of these Guidelines.

(e) The Department reserves the right to do the following:

(1) Score an application as submitted in the event information is missing from the application; and

(2) Request clarification of unclear or ambiguous statements made in an application, and other supporting documents, when doing so will not impact the competitive scoring of the application. No additional information may be introduced into the application documentation.

(f) Applications selected for funding shall be approved at amounts, terms, and conditions specified by these Guidelines and the NOFA.

(g) Each project must achieve the minimum scores in the Development Team Experience, Supportive Services plan, and Readiness to Proceed scoring categories, as follows:

(1) Development Team Experience: 18 points

(2) Supportive Services plan: 10 points

(3) Readiness to Proceed: 15 points

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 111. Application Selection Criteria

The criteria detailed below and summarized in the following table shall be used to rate applications. In the event of tied point scores, the following tiebreakers shall be used to determine which project is selected for funding, in the order listed:

(1) The Readiness to Proceed point score, pursuant to Section 111(f) of these Guidelines; and

(2) The Supportive Services plan point score, pursuant to Section 111(c) of these Guidelines

	Maximum Applicable Points
Development Team Experience	
Developer Experience	10
Applicant Ownership	5
Property Management	5

Lead Service Provider	15
Total Development Team Experience	**35**
Supportive Housing Units	25
Supportive Services plan	25
Utilization of Funds to Offset Requests	10
Leverage of Rent/Op Subsidies	15
Readiness to Proceed	30
Confirmation of Local Need	5
Location Efficiency and Access to Destinations	5
TOTAL APPLICABLE POINTS	**150**

(a) Development Team Experience (35 points maximum). The Applicant must achieve a minimum of 18 points from this section to receive an award.

(1) Developer Experience (10 points maximum)

a. Applications will be scored based on the number of affordable rental housing developments completed by the project developer over the past five years, including Supportive housing projects completed in the last three years serving persons similar to the Target Population. Applicant should address whether these projects were completed timely and within budget. Delays and cost overruns should be explained.

b. Two points will be awarded for each completed development that was timely and within budget, up to a maximum of ten points.

(2) Applicant Ownership and Operations Experience (5 points maximum)

a. Applications will be scored based on the experience of the Applicant in owning or operating (under a long-term master lease or similar arrangement) supportive and/or affordable rental housing developments.

b. The Applicant's experience includes the experience of its affiliated entities or principals (including management-level staff), but not the experience of board members. If there are multiple entities that comprise the ownership entity of the proposed project, the score will be based on the experience of the entity with a controlling interest in the ownership entity and a substantial and continued role in the project's operations, as evidenced in the ownership entity's legal documents.

c. One-half point will be awarded for each affordable housing project, and one point will be awarded for each Supportive housing project, up to a maximum of five points.

(3) Property Manager Experience (5 points maximum)

a. Applications will be scored based on the number of affordable and Supportive housing developments managed by the designated property management agent at the time of application. One-half point will be awarded for each affordable housing development, and one point will be awarded for each Supportive housing development, up to a maximum of five points.

b. Points will be awarded for Supportive housing developments that have been in operation for at least two years with units restricted to people

experiencing homelessness.

(4) Lead Service Provider Experience (15 points maximum)

a. Points will be awarded for experience in the last five years providing comprehensive case management and tenancy support to people experiencing homelessness, and for demonstrated expertise working with the Target Population.

b. Experience must be documented through contracts with public agencies, housing owners, or foundations for services in housing projects with at least ten units subject to agreements with public agencies restricting rent or occupancy to Homeless persons or households, or in publicly funded tenant-based housing assistance programs serving at least ten members of the Target Population.

Points will be awarded for the following:

1. Years of experience in permanent Supportive housing (3 points maximum).
   - i. One to two years (1 point)
   - ii. Three years to four years (2 points)
   - iii. Five years or more (3 points)
2. Number of projects or contracts in permanent Supportive housing (3 points maximum).
   - i. One to two projects (1 point)
   - ii. Three to four projects (2 points)
   - iii. Five or more projects (3 points)
3. Years of experience serving the Target Population (3 points maximum).
   - i. One to two years (1 point)
   - ii. Three years to four years (2 points)
   - iii. Five years or more (3 points)
4. Experience providing comprehensive case management, where members of the Target Population were at least 20 percent of the Lead Service Provider's clients during the years for which points are sought in any of the following (two points for either of the following):
   - i. Permanent Supportive housing restricted to members of the Target Population; or
   - ii. Permanent Supportive housing not restricted to members of the Target Population, with documented experience providing Homeless services with documented retention rates of at least 85 percent after 12 months.

   To receive points under subsection i. or ii. above, the Lead Service Provider must have current staff expertise and organizational experience:
   - i. Connecting members of the Target Population and/or Homeless individuals with community-based health care services, including linkage to primary care services and behavioral health care; and
   - ii. Staff expertise and experience must be documented through resumes, job descriptions, contracts, staff training descriptions, and letters from Continuums of Care or other supportive services organizations.

5. Experience of a partner agency if the following conditions are satisfied (2 points):
    i. An executed agreement between the two agencies must be submitted with the application for HHC assistance; and
    ii. The agreement must have a term of at least five years and detail the cultural competency services to be provided by the partner agency. These services must include:
        a. Technical assistance with program development;
        b. Training and mentoring of Lead Service Provider leadership and staff for the proposed project;
        c. Assistance with hiring project staff;
        d. Assistance with developing community linkages;
        e. Other technical assistance as needed; and
        f. An agreement to provide services to members of the Target Population residing in the project that are referred by the Lead Service Provider.

6. Documented success in meeting or exceeding specified outcome measures for housing stability under a government contract for at least two years as a Lead Service Provider in Permanent Supportive housing serving persons experiencing homelessness. (2 points)

(b) Supportive Housing (25 points maximum).

(1) Applications will be scored based on the percentage of total project units restricted as Supportive housing in accordance with the table in subsection (2) below.

(2) To receive any points in this category, a minimum of 5 percent of total project units must be restricted as Supportive housing.

The scoring table is as follows:

Percentage of Total Project Units Restricted as Supportive Housing	Points
5%	**5**
10%	**9**
15%	**13**
20%	**17**
25%	**21**
30% or more	**25**

(c) Supportive Services Plan (25 points maximum). The Applicant must achieve a minimum of 10 points from this section to receive an award.

(1) Applications for projects will be scored based on the following:
    a. Quality and Quantity of Services (7 points maximum)
        1. The services provided are of appropriate quality and quantity for the Target Population. (2 points)

2. Staff experience, credentials, and job duties include appropriate skills in cultural competency. (2 points)
3. The service delivery model, tailored to Homeless people impacted with one or more chronic health or behavioral health conditions, that includes, but is not limited to, the following: (3 points)
    i. Use of a critical time intervention or assertive community treatment model
    ii. Cognitive behavioral therapy
    iii. Trauma-informed care
    iv. Motivational interviewing and other tools to encourage engagement in services
    v. Other practices recognized as evidenced-based by the Substance Abuse and Mental Health Services Administration (SAMHSA), DHCS, HUD, or other federal or state public agencies

b. The accessibility of services, whether they are on-site or in close proximity to the project, including the hours they are available, and the frequency, travel time and cost of transportation required to access them, including both public transportation and private transportation services (e.g. van owned by the provider), and how the service provider will assist in the expense of public transportation (e.g., provide tokens, negotiate discounts, provide their own shuttle service, etc.). (2 points)
c. Adherence to Section 113, Housing First principles in the provision of services, including provision of flexible services that facilitate Permanent housing access and housing stability. (2 points)
d. The degree to which the physical building space supports social interaction, the provision of services and ensures the safety of all residents, especially those more vulnerable, such as persons with a history of trauma, children, elderly, etc. (1 point)
e. The levels of linkages with local systems for ending homelessness and community-based health care resources for members of the Target Population, including: (5 points)
    1. Participation, verified by the local Continuum of Care, in a local CES that is fully established.
    2. The degree of coordination with primary care providers, behavioral health providers, and health care facilities.

(2) Resident Involvement (3 points maximum)
Points will be awarded based on the quality of:
a. Strategies to engage residents to encourage participation in services (1 point);
b. Strategies to engage residents in services planning and operations (1 point); and
c. Tenant satisfaction surveys to inform and improve services, building operations, and property management. (1 point)

(3) The adequacy of the services budget and the reliability over time of services funding (5 points maximum)
Points will be awarded based on:

a. The adequacy and accuracy of budgeted income sources and uses and the consistency of these amounts with other sections of the services plan. (1 point)
b. The completeness, accuracy, specificity and clarity of the budget document. (1 point)
c. The extent to which the major services funding sources have been accessed by the designated service providers or Applicant in the past. (1 point)
d. The track record of the Applicant and providers in filling gaps in services funding left by the loss of major funding sources. (1 point)
e. The percentage of the total services budget that is committed at the time of application. (1 point)

(d) Utilization of Funds to Offset Requests (10 points maximum)

(1) Applications will be scored based on the ratio of permanent affordable development funding attributable to Assisted Units from sources other than NHTF to the requested NHTF loan amount. Deferred developer fees and funds deposited in a reserve to defray scheduled operating deficits will not be counted in this computation. Land donations will be counted where the value is established by a current appraisal.

(2) For projects utilizing 9 percent competitive low-income housing tax credits, 0.375 points will be awarded for each full 5 percentage point increment above 50 percent. For example, an application proposing other funds equal to 100 percent of the NHTF funds will receive 3.75 points. An application where other funds equal 250 percent of NHTF funds will receive 10 points.

(3) For other projects not utilizing 9 percent competitive low-income housing tax credits, 0.75 points will be awarded for each 5 percentage point increment above 50 percent. For example, an application proposing other funds equal to NHTF funds will receive 7.5 points, and an application where other funds equal 150 percent of NHTF funds will receive 10 points.

(e) Leverage of Rental or Operating Subsidies (15 points maximum)

(1) Applications will be scored based on the percentage of Assisted Units that either:
a. Have committed project-based rental or operating subsidies substantially similar in terms to project-based housing choice vouchers to indicate a high likelihood of receiving similar funding for the proposed project; or
b. Are restricted to rents not exceeding 30 percent of household income, with project feasibility determined based on the assumption that rents will be affordable to tenants of existing projects targeting Homeless populations, as specified in the HHC application.

(2) Project-based housing choice vouchers will be deemed committed if they have been allocated to the project and approved by HUD, or if the Department approves other evidence that they will reliably be available (such as a letter from the housing authority committing to project-based housing choice

vouchers to the project).

(3) One point will be awarded for each 5 percentage point increment, up to a maximum of 15 points.

(f) Readiness to Proceed (30 points maximum). The Applicant must achieve a minimum of 15 points from this section to receive an award.

The Supportive Services must be fully implemented and available for use by the tenant at the time of occupancy. Points will be awarded as shown below to projects for each of the following circumstances as documented in the application. Any application demonstrating that a particular category is not applicable to project readiness for the subject project shall be awarded points in that category.

(1) Obtained enforceable commitments for all construction financing, not including tax-exempt bonds, low-income housing tax credits, and funding to be provided by another Department program. Other Department funds must be awarded prior to the application deadline. (5 points)

(2) Completion of the California Environmental Quality Act, if necessary and not entitled to a streamlined review under AB 2162, and
   a. Phase I Environmental Site Assessment (ESA-ASTM) for projects with NHTF only, or
   b. If any other federal funding sources are utilized, the project must complete a Phase I Environmental Site Assessment with the National Environmental Policy Act. (5 points)

(3) Obtained all necessary and discretionary public land use approvals, except building permits and other ministerial approvals, or documented to be an eligible project under AB 2162. (5 points)

(4) 5 points will be awarded if either:
   a. The Applicant has fee title ownership to the site or a long-term leasehold securing the site meeting the criteria for HHC site control; or
   b. The Applicant can demonstrate that the working drawings are at least 50 percent complete, as certified by the project architect;

(5) Obtained local design review approval to the extent such approval is required. (5 points)

(6) Obtained commitments for all deferred-payment financing, grants and subsidies, in accordance with TCAC requirements and with the same exceptions as allowed by TCAC. Deferred payment financing, grant funds, and subsidies from other Department programs must be awarded prior to application deadline. (5 points)

(g) Local Need (5 points maximum)

More than 400 individuals are Homeless in the Applicant's geographic jurisdiction using the latest PIT count and as stated in the NOFA.

(h) Location Efficiency and Access to Destinations (5 points maximum)

Location Efficiency and Access to Destinations refers to reasonable access and proximity to amenities, services, and public transportation that allows members of the Target Population to have choices in accessing resources for independent living.

Points may be awarded cumulatively across the categories below up to a total of five points. Applicants must provide a map demonstrating proximity for items (1) and (2) to be eligible for the respective points.

(1) Projects located where there is a rapid transit station, light rail station, commuter rail station, ferry terminal, bus station, or public bus stop within one-half mile (one mile for Rural Areas) from the site, with service at least every 30 minutes (or at least two departures during each peak period for a commuter rail station or ferry terminal) during the hours of 7 a.m. - 9 a.m. and 4 p.m. – 6 p.m., Monday through Friday. (1 point)

(2) Projects that provide a map highlighting the location of the existing and operational services within one-half mile of the project area (two miles for Rural Areas), as follows:
   a. (1 point) Grocery store which meets the CalFresh Program requirements;
   b. (1 point) Medi-Cal clinic that accepts Medi-Cal payments;
   c. (1 point) Public elementary, middle or high school; and
   d. (1 point) Licensed child care provider.

(i) Applicants will be subject to the appeal process as detailed in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 112. Supportive Services

(a) Each application must include a project-specific Supportive Services plan. This plan is to be developed by the Lead Service Provider and the property manager and shall include information listed in (c) and (d) of this section. Recipients must utilize a Lead Service Provider.

(b) The property management staff and service providers must make participation in Supportive Services by HHC tenants voluntary. Access to or continued occupancy in housing cannot be conditioned on participation in services or on sobriety. The Supportive Services plan must describe the services to be made available to HHC tenants in a manner that is voluntary, flexible and individualized, so HHC tenants may continue to engage with supportive services providers, even as the intensity of services needed may change. Adaptability in the level of services should support tenant engagement and housing retention.

(c) Using evidence-based models, the following Supportive Services shall be made

available to HHC tenants based on tenant need. Except as otherwise noted below, the following required services shall be provided onsite at the project or offsite at another location easily accessible to tenants, with the majority of case management services offered on-site:

(1) Assistance accessing and linking tenants to Medi-Cal enrollment and enrollment in other benefits the tenant may be eligible for;

(2) Case management;

(3) Peer support activities;

(4) Support in linking to behavioral health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups;

(5) Support in linking to primary care services, including access to routine and preventive health and dental care, medication management, and wellness services;

(6) Benefits counseling and advocacy, including assistance in accessing Supplementary Security Income/State Supplemental Payment (SSI/SSP);

(7) Basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, working with a landlord, getting along with neighbors, and money management); and

(8) Services for persons with co-occurring mental and physical disabilities or co-occurring mental and substance use disorders not listed above.

The following Supportive Services are not required to be made available but are encouraged to be part of a project's Supportive Services plan.

(1) Recreational and social activities;

(2) Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process;

(3) Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work; and

(4) Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

(d) The following additional information shall be provided in the Supportive Services plan:

(1) Description of the Target Population to be served and identification of any

additional subpopulation target or occupancy preference for the HHC project that the Applicant wishes to undertake beyond what is permitted under the Target Population requirements. Any additional subpopulation targeting or occupancy preference for the HHC project must be approved by the Department prior to construction loan closing and must be consistent with federal and state fair housing requirements;

(2) Description of tenant outreach, engagement, and retention strategies to be used;

(3) Description of each service to be offered, how frequently each service will be offered or provided depending on the nature of the service, who is anticipated to be providing the services, the location, and general hours of availability of the services;

(4) For services provided off-site, the plan must describe what public or private transportation options will be available to HHC tenants in order to provide them reasonable access to these services. Reasonable access is access that does not require walking more than one-half mile;

(5) Description of how the Supportive Services are culturally and linguistically competent for persons of different races, ethnicities, sexual orientations, gender identities, and gender expressions. This includes explaining how services will be provided to HHC tenants who do not speak English or have other communication barriers, including sensory disabilities, and how communication among the services providers, the property manager and these tenants will be facilitated;

(6) Estimated itemized budget and sources of funding for services;

(7) Description of how the supportive services staff and property management staff will work together to prevent evictions, to adopt and ensure compliance with harm reduction principles, and to facilitate the implementation of reasonable accommodation policies from rent-up to ongoing operations of the project;

(8) General service provider and property manager communication protocols;

(9) Description of how the physical design of the project fosters tenant engagement, onsite supportive services provision, safety and security, and sustainability of furnishings, equipment, and fixtures; and

(10) Other information needed by the Department to evaluate the Supportive Services to be offered consistent with the Program.

(e) Copies of draft written agreements or memoranda of understanding (MOUs) that identify the roles and responsibilities of the Recipient, the project owner, other service providers, and the property manager must be provided. The draft written agreements or MOUs must be materially consistent with the information set forth in the Supportive Services plan.

The Department may request that any necessary updates to the Supportive Services plan or related documents, including fully executed written agreements between the county, service providers, the project owner, and the property manager, be provided prior to the beginning of the initial rent-up period or prior to permanent loan closing.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 113. Housing First

(a) Projects shall employ Housing First practices that are documented in the application, property management plan and Supportive Services plan. Adherence to the Housing First core components pursuant to Welfare and Institutions Code Section 8255(b).

(b) For all HHC funded projects, Housing First property management and services delivery practices shall be followed. Housing First practices include the following:

1. Tenant selection practices shall be done in conjunction with the local Coordinated Entry System and promote the acceptance of Applicants regardless to their sobriety or use of substances, completion of treatment, or agreement to participate in services;

2. Applicants are not rejected based on poor credit or financial history, poor or lack of rental history, or criminal convictions unrelated to tenancy, or behaviors that indicate a lack of “housing readiness”;

3. Applicants are assisted in making application for tenancy and reasonable accommodation requests;

4. Supportive Services are flexible and voluntary and focus on housing stability, engagement, and problem solving over therapeutic goals; and

5. The lack of policies or practices regimenting daily activities or limiting privacy, visitors, or the individual’s ability to engage freely in community activities or to manage their own activities of daily living.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 114. Tenant Selection

Tenants must meet income requirements in Section 105 and Target Population requirements in Section 102.

Recipients shall accept referrals through use of a CES or other similar system in accordance with the provisions of 25 CCR Section 8305, and in compliance with Housing First requirements consistent with the core components set forth in Welfare and Institutions Code Division 8 Chapter 6.5 Section 8255 subsection (b), and basic tenant protections established under federal, state, and local law.

(a) Reasonable selection criteria, as referred to in 25 CCR Section 8305(a)(1), shall include priority status under a local CES developed pursuant to 24 CFR 578.7(a)(8).

(b) If the CES existing in the county cannot refer persons in the Target Population, the alternative system used must prioritize those with the greatest needs among those for referral to available Assisted Units.

(c) Recipients shall accept tenants regardless of sobriety, participation in services or treatment, history of incarceration, credit, or history of eviction in accordance with practices permitted pursuant to WIC Section 8255 or other federal or state project funding sources.

(d) Projects must also provide a preference for accessible units to persons with disabilities requiring the features of the accessible units in accordance with Section 10337(b)(2) of the TCAC regulations.

The requirements of 25 CCR Section 8305 (a)(4)(A) and 25 CCR Section 8305 (a)(4)(D) shall be implemented as approved by the Department in a manner that is consistent with the requirements of the CES.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 115. Rental Agreements and Grievance Procedures

Rental or occupancy agreements and grievance procedures for Assisted Units shall comply with 25 CCR Section 8307 and 24 CFR 93.303. Tenants shall not be required to maintain sobriety, be tested for substances, or participate in services or treatment.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 116. Vulnerable Populations Best Practices

The following best practices should be incorporated in the construction of projects that receive funding from HHC, to the extent possible. These best practices work

to further the safety and physical and mental well-being of residents within a project.

(a) General best practices for all developments:

(1) Safety Features:
   a. Site selection and development of the project should consider the safety concerns of the prospective tenants.
   b. Building entrance and exit points should only allow admittance to residents or guests that residents admit.
   c. Common areas within the project should be oriented so as to have:
      1. Two ways to enter or exit the area;

2. Visibility to the area from outside of it, i.e. windows in walls or doors; and
3. A centralized location, to the extent possible.

d. Safety lighting that reduces or eliminates blind or dark spaces where people can hide.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(b) For those populations that have a history of sexual trauma and/or domestic violence:

(1) Safety features incorporate all the general best practices and include the following:

a. For projects that will also be serving women with a history of domestic violence or sexual trauma:

1. Designate at least 25 percent of the Assisted Units will be for women with a history of domestic violence or sexual trauma and/or women with children, thereby ensuring women are not a small minority of the tenancy.
2. Design projects to provide separate and secure floors, wings, or buildings for women with a history of domestic violence or sexual trauma and/or women with children. These separate and secure areas should restrict access to only the residents in the secured area.

b. Security cameras:

1. At entrances, exits and common areas (including hallways, elevators, and stair wells);
2. Written policy on the use of the cameras to specify who has access to see the videos, who monitors the surveillance, and under what conditions footage would be released to the authorities; and
3. Camera recordings should be maintained for at least 30 days.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

The project should have 24-hour security if it serves persons impacted by domestic violence, transition age youth and other vulnerable populations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2) and 53595.

Section 117. Reporting Requirements

Recipient must collect and report data, as described in Section 53593, to the Department at annual and midyear intervals. Reporting of the following is required:

(a) Not later than 90 days after the end of each project's fiscal year, the Recipient shall submit an independent audit of the development prepared by a certified public accountant and in accordance with the Department's current audit requirements and all other applicable requirements, as stated by law or included in the NOFA.

(b) Recipients shall report on the sources of tenant referrals for the project and submit both client data and performance outcome data to the Department. Tenant data may include, but is not limited to, demographic information. Performance outcome data shall include, but is not limited to, information on housing stability, tenant satisfaction as measured in a survey, and changes in income and benefits received.

(c) Recipients shall report the number of participants living in the Supportive housing project after 12 months, 24 months, and 36 months, as relevant.

(d) Recipients shall report the number of participants and the type of interventions offered through the grant funds.

(e) Recipients shall report on the number of participants who exited the project each year and where they exited to, including other Permanent housing, homelessness, or death.

(f) To the extent available and feasible, Recipients shall provide data on the impact of the Program on participants' use of corrections systems and law enforcement resources.

(g) If Recipient is a local government, must comply with 2 CFR Part 512, as outlined in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53593.

Section 118. Operating Budgets

The Recipient shall submit proposed operating budgets to the Department prior to occupancy, and annually thereafter. These budgets shall be subject to Department approval and comply with the requirements in 25 CCR Section 7326.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 119. Federal and State Overlays

(a) Federal Overlays. Activities funded with HHC funds are required to comply with 24 CFR Part 93.350 and 24 CFR Part 93.301. Compliance with these requirements include, but are not limited to, environmental provisions, federal Davis-Bacon Wage requirements and state prevailing wage laws, relocation, Equal Opportunity and Fair Housing, Fair Housing Amendments Act, Affirmative Marketing, Section 504 of the Rehabilitation Act and its implementing regulations, and the Americans with Disabilities Act and its implementing regulations, Section 3 (employment of low-income persons), Violence Against Women Act, and Single Audit report 2 CFR Part 200.512. Failure to comply with federal overlays could result in significant project cost increases, and rejection of the HHC application.

(b) State Overlays. Article XXXIV of the California Constitution requires local voter approval before any state public body can develop, construct, or acquire a low-rent housing project in any manner. However, the Public Housing Election Implementation Law (Health & Safety. Code, §§ 37000 - 37002) provides clarification as to when Article XXXIV is applicable.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(2).

Section 120. Legal Documents

After a Recipient is sent a letter providing notice of award pursuant to a NOFA, and prior to actual disbursement of funds pursuant to that award, the Department and Recipient shall enter into a state “Standard Agreement” that shall constitute a conditional commitment of said funds. The Standard Agreement shall require the Recipient to comply with the requirements and provisions of these Guidelines, and generally applicable state contracting rules and requirements. The Standard Agreement shall encumber state moneys in an amount no more than as established in the NOFA and said amount shall be consistent with the application and corresponding award letter. The Standard Agreement shall contain the terms necessary to ensure the Recipient complies with all HHC-NHTF requirements, including, but not limited to, the following:

(a) Requirements for the execution of a promissory note, operating reserve agreement, or other project-specific contracts as may be applicable;

(b) Requirements set forth in the NOFA;

(c) Requirements, where appropriate, for the execution and recordation of covenants, regulatory agreements, or other instruments restricting the use and occupancy of and appurtenant to the project and the property thereunder (for the purposes of these Guidelines, all such documents are collectively herein referred to as the HHC regulatory agreement;

(d) Requirements for the execution of a Deed of Trust or other security instrument securing the debt owed by the borrower to the Department for the amount of the award. The Deed of Trust must be recorded against the fee estate underlying the property; leasehold security will not be accepted unless such security strictly meets

the requirements set forth in 25 CCR Section 8316;

(e) The Recipient's responsibilities for timing and completion of the project, as well as all reporting requirements;

(f) Remedies available to the Department in the event of a violation, breach or default of the Standard Agreement; and

(f) All other provisions necessary to ensure compliance with the requirements of HHC and applicable state and federal law.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2), 53593 and 53595.

Section 121. Defaults and Loan and/or Grant Cancellations

(a) In the event of a breach or violation by the Recipient of any of the provisions of HHC-NHTF requirements, the regulatory agreement, the promissory note, or the deed of trust, or any other agreement pertaining to the project, the Department may give written notice to the Recipient to cure the breach or violation within a period of not less than 15 days. If the breach or violation is not cured to the satisfaction of the Department within the specified time, the Department, at its option, may declare a default under the relevant document(s) and may seek legal remedies for the default, including but not limited to the following:

(1) The Department may accelerate all amounts, including outstanding principal and interest, due under the loan and demand immediate repayment thereof. Upon a failure to repay such accelerated amounts in full, the Department may proceed with a foreclosure in accordance with the provisions of the Deed of Trust and state law regarding foreclosures.

(2) The Department may seek, in a court of competent jurisdiction, an order for specific performance of the defaulted obligation or the appointment of a receiver to operate the project in accordance with HHC-NHTF requirements.

(3) The Department may seek such other remedies as may be available under the relevant agreement or any law as it relates to both the loan and the COSR grant.

(4) Suspension from future Department funding awards.

(5) The Department may seek other remedies set forth in the relevant agreement or any other applicable legal or equitable remedies law.

(b) If the breach or violation involves charging tenants rent or other charges in excess of those permitted under the regulatory agreement, the Department may demand the return of such excess rents or other charges to the respective households. In any action to enforce the provisions of the regulatory agreement, the Department may seek, as an additional remedy, the repayment of such overcharges.

(c) The Department may cancel loan commitments or COSR grants under any of the following conditions:

(1) The objectives and requirements of HHC cannot be met;

(2) Implementation of the project cannot proceed in a timely fashion in accordance with the approved plans and schedules;

(3) Special conditions have not been fulfilled within required time periods;

(4) There has been a material change, not approved by the Department, in the principals or management of the Recipient or project; or

(5) If the Recipient fails to apply for Tax Credit funding, which they relied on for project feasibility in their application, within 18 months of the HHC award date.

The Department, in writing and upon demonstration by the Recipient of good cause, may extend the date for compliance with any of the conditions in this subsection, as long as these extensions are within the established/agreed upon deadlines established in the NOFA.

(d) Upon receipt of a notice from the Department of intent to cancel the loan or request to repay the grant, the Recipient shall have the right to appeal to the Director.

(e) The Department may use any funds available to it to cure or avoid a Recipient's default on the terms of any loan or other obligation that jeopardizes the fiscal integrity of a project or the Department's security in the project. Such defaults may include defaults or impending defaults in payments on mortgages, failures to pay taxes, or failures to maintain insurance or required reserves. The payment or advance of funds by the Department pursuant to this subsection shall be solely within the discretion of the Department and no Recipient shall be entitled to or have any right to payment of these funds. All funds advanced pursuant to this Subsection shall be part of the HHC loan or COSR grant and, upon demand, due and payable to the Department. Where it becomes necessary to use state funds to assist a project to avoid threatened defaults or foreclosures, the Department shall take those actions necessary, including, but not limited to, foreclosure or forced sale of the project property, to prevent further, similar occurrences and ensure compliance with the terms of the applicable agreements.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(2), 53593 and 53595.

Article II. Building Homes and Jobs Trust Fund Allocation

Section 200. Purpose and Scope

(a) In September of 2017, AB 74 was signed into law. This legislation authorizes the California Department of Housing and Community Development (Department) to develop the Housing for a Healthy California (HHC) program to create Supportive housing for individuals who are recipients of or eligible for health care provided through the California Department of Health Care Services (DHCS) Medi-Cal program. The goal of HHC is to reduce the financial burden on local and state resources due to the overutilization of emergency rooms or incarceration as the first point of health care provision for people who are Chronically homeless or Homeless and a High-cost health user. The Department shall coordinate with the DHCS, consistent with state and federal privacy law, to match Program participant data to Medi-Cal data to identify outcomes among participants, as well as changes in health care costs and utilization associated with housing and services provided under HHC.

(b) AB 74 allows the Department to utilize revenues appropriated to the Department from other revenue sources for HHC purposes. As directed in the 2018-2019 state Budget Act, the Department will utilize a portion of moneys collected in calendar year 2018 and deposited into the Building Homes and Jobs Trust Fund for the HHC program. The Department will allocate these funds competitively to counties for acquisition, new construction or reconstruction and rehabilitation, administrative costs, capitalized operating subsidy reserves (COSR), and rental subsidies for existing Supportive housing to assist HHC's Target Population. The Department has elected to incentivize utilizing locally committed funding in an amount at least equivalent to the requested HHC funding amount. Note, funds applied pursuant to Health and Safety Code Section 53594(a)(1) acquisition funding, new construction, and rehabilitation shall comply with Federal Housing Trust Fund regulations.

(c) In addition to applicable state and federal laws and regulations, these guidelines (hereinafter "Guidelines") implement, interpret, and make specific the HHC program authorized by Part 14.2 (commencing with Section 53590) of Division 31 of the Health and Safety Code and for Fiscal Year 2018 Chapter 2.5 (commencing with Section 50470) of Part 2 of Division 31 of the Health and Safety Code.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53591(a)(1), 53594 and 50472.

Section 201. Definitions

All terms not defined below shall, unless their context suggests otherwise, be interpreted in accordance with the meaning of terms described in Part 14.2 of Division 31 of the Health and Safety Code (commencing with Section 53590).

(a) “Applicant” means a County, as defined below.

(b) “Area Median Income” or “AMI” means the most recent applicable County median family income published by HUD.

(c) “Assisted Unit” means a housing unit that is subject to the program’s rent and/or occupancy restrictions as a result of the financial assistance provided under the program.

(d) “Case Manager” means a social worker or other qualified individual who works with a tenant to offer individualized service planning that is flexible and creative to help the tenant gain housing stability. It includes working in collaboration with the tenant to plan, assess, coordinate, and reassess the tenant’s needs, as well as referrals and advocacy and connection to community support to meet tenants’ supportive services needs. Services include, but are not limited to: tenancy support services, coordination of medical and behavioral health, substance use disorder treatment, employment services, life skills training, peer support, and crisis management interventions. Resident service coordinators are not Case Managers.

(e) “Chronically homeless” has the same meaning as in Part 91.5 and 578.3 of Title 24 of the Code of Federal Regulations, except that people who were Chronically homeless before entering an institution would continue to be defined as Chronically homeless before discharge, regardless of length of stay, as those parts read on January 1, 2018.

(f) “Continuum of Care” is defined in 24 CFR Section 578.3.

(g) “Coordinated Entry System” or “CES” means a centralized or coordinated process developed pursuant to 24 CFR Section 578.7(a)(8), designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

(h) “County” means a county, city and county, or a city collaborating with a county to secure services funding.

(i) “DHCS” means the state Department of Health Care Services.

(j) “Department” means the Department of Housing and Community Development.

(k) “Development Sponsor” or “Sponsor”, as defined in Section 50675.2 of the Health and Safety Code and subdivision (c) of Section 50669 of the Health and Safety Code,

means any individual, joint venture, partnership, limited partnership, trust, corporation, cooperative, local public entity, duly constituted governing body of an Indian Reservation or Rancheria, or other legal entity, or any combination thereof, certified by the Department as qualified to own, manage, and rehabilitate a rental housing development. A Development Sponsor may be organized for profit, limited profit or be nonprofit, and includes a limited partnership in which the Development Sponsor, or an affiliate of the Development Sponsor, is a general partner.

(l) “Distributions” has the same meaning as under 25 CCR Section 8301(h).

(m)“Fair Market Rent” or “FMR” means the rent, including the cost of utilities, as established by HUD pursuant to Parts 888 and 982 of Title 24 of the Code of Federal Regulations, as those parts read on January 1, 2018, for units, by number of bedrooms, that must be paid in the market area to rent privately owned, existing, decent, safe, and sanitary rental housing of non-luxury nature with suitable amenities.

(n) "Fiscal Integrity" means, for any project for any given period of time during the term specified in the program’s regulatory agreement, that the total Operating Income for such project for such period of time, plus funds released pursuant to the Program documents from the project’s operating reserve account(s) during such period of time is sufficient to: (1) pay all current Operating Expenses for such project for such period of time; (2) pay all current mandatory debt service (excluding deferred interest) coming due with respect to such project for such period of time; (3) fully fund all reserve accounts established pursuant to the Program documents for such project for such period of time; and (4) pay other costs permitted by the Program documents for such project for such period of time. The ability to pay any or all the permitted annual distributions for a project shall not be considered in determining the Fiscal Integrity of a project.

(o) “Grantee” means an eligible Applicant that has been awarded funds under the program.

(p) “HHC” means the Housing for a Healthy California Program administered by the Department.

(q) “Health Homes Program” means the Health Homes Program, administered by the Department of Health Care Services, established pursuant to Article 3.9 (commencing with Section 14127) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(r) “High-cost health users” means people who have had either at least three emergency department visits or one hospital inpatient stay over the last year.

(s) “Homeless” has the same meaning as in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018.

(t) “Housing First” has the same meaning as in Welfare and Institutions Code Section 8255.

(u) “Lead Service Provider” or “LSP” means the organization that has the overall responsibility for the provision of Supportive Services and implementation of the Supportive Services plan. The LSP may directly provide comprehensive case management services or contract with other agencies that provide services.

(v) “Long-term rental assistance” means a rental subsidy provided to a housing provider, including a developer leasing affordable housing, to assist a tenant to pay the difference between 30 percent of the tenant’s income and Fair Market Rent or reasonable market rent as determined by the Department.

(w) “NOFA” means a Notice of Funding Availability.

(x) “Operating Expenses” has the same meaning as in 25 CCR Section 8301.

(y) “Operating Income” has the same meaning as in 25 CCR Section 8301.

(z) “Operating Cost Assistance Reserves” has the same meaning as in 25 CCR Section 8308.

(aa) “Permanent housing” means a housing unit where the landlord does not limit the length of stay in the housing unit, the landlord does not restrict the movements of the tenant, and the tenant has a lease and is subject to the rights and responsibilities of tenancy, pursuant to Chapter 2 (commencing with Section 1940) of Title 5 of Part 4 of Division 3 of the Civil Code.

(bb) “Point in Time Count” or “PIT” refers to an annual count of sheltered and unsheltered homeless persons on a single night in January.

(cc) “Program” means the Housing for a Healthy California Program created by this part.

(dd) “Supportive housing” means housing with no limit on length of stay, that is occupied by the Target Population, and that is linked to onsite or offsite services that assist the Supportive housing resident in retaining the housing, improving his/her health status, and maximizes his/her ability to live, and when possible, work in the community.

(ee) “Supportive Services” means social, health, educational, income support and employment services and, benefits; coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits.

(ff) “Target Population” means a person who is Chronically homeless or is Homeless and a High-cost health user upon initial eligibility, is a Medi-Cal beneficiary, is eligible for Supplemental Security Income, is eligible to receive services under a program providing services promoting housing stability, and is likely to improve his or her health conditions with Supportive housing.

(gg) “UMR” means the Uniform Multifamily Regulations commencing with 25 CCR Section 8300.

(hh) “Whole Person Care” Pilot or “WPC” has the meaning as described in the Medi-Cal 2020 Waiver Special Terms and Conditions (STCs), Sections 110-126, as approved by the federal Centers for Medicare and Medicaid Services on December 30, 2015.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53590 and 53595.

Section 202. Minimum Requirements

The Applicant shall comply with the requirements of HHC and all applicable federal and state laws.

(a) The Applicant shall meet all the following minimum requirements:

(1) Has identified a source of funding for providing intensive services promoting housing stability. Funding for these services may include, but is not limited to, one of more of the following:
   a. County general funds.
   b. WPC pilot program funds, to the extent those funds are available, or the WPC program has been renewed
   c. The Health Homes Program
   d. MHSA program
   e. Managed Care Organization
   f. Other County-controlled funding to provide these services to eligible participants

(2) Has developed a process for administering grant funds implementing affordable and Supportive housing projects. The agency the Applicant is partnering with, or the applying housing agency, must have either administered rental assistance or funded an affordable or Supportive housing project within the past three years.

(3) Agrees to collect and report data, as described in Section 219, to the Department.

(4) Must be compliant with both the housing element and their annual progress report submittals.

(b) The Applicant shall submit an application that meets the following requirements:

(1) The request for funding shall promote housing for persons who meet all the following requirements:
   a. Is Chronically homeless, or is homeless and a high-cost health user upon initial eligibility
   b. Is a Medi-Cal beneficiary
   c. Is eligible for Supplemental Security Income
   d. Is eligible to receive services under a program providing services promoting housing stability, including, but not limited to, the following:
      1. The WPC pilot program, to the extent the WPC program is available or has been renewed
      2. The Health Homes Program

3. A locally controlled service program funding or providing services in Supportive housing

e. Is likely to improve his or her health conditions with Supportive housing

(2) The use of funds proposed by the Applicant shall be clearly connected to the goals and strategies pursuant to Section 53591(a)(1).

(3) The amount requested shall not exceed the maximum amount specified in Section 208.

(4) The proposed projects shall be financially feasible for the duration of the HHC rental subsidy.

(5) A resolution from the County board of supervisors, or other controlling body, that authorizes the County to apply for funding and coordinate referrals and access to health care services to HHC tenants, such as a WPC pilot program, Health Homes Program, or other community-based program funding services.

(6) A County Application Plan as specified in Section 211.

(c) A County subrecipient(s) of HHC funds cannot be debarred or suspended from any state programs.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Sections 53592 and 53595.

Section 203. Eligible Uses

(a) A County shall use grants awarded pursuant to this part for any of the following:

(1) Acquisition, new construction, or reconstruction and rehabilitation of (a) project(s). Under this use, Applicants will be subject to Article I, Sections 103(a)(1), 104, 105, 106, 107, and 109(a) of these Guidelines.

(2) Operating assistance, which may include either or both of the following:

a. Long-term rental assistance to private landlords for periods as referenced in the NOFA, subject to renewal grants.

b. A Capitalized Operating Subsidy Reserve (COSR) for at least 15 years to pay for operating costs of an apartment or apartments receiving capital funding to provide Supportive housing to the Target Population.

(3) A County's administrative costs, as determined by the Department NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 204. Site and Neighborhood and Property Standard Requirements

In carrying out the site and neighborhood standards with respect to new construction, the requirements of 24 CFR 983.57(e)(2) apply. These standards do not apply to rehabilitation projects. However, if project-based vouchers are used in an assisted rehabilitation unit, the site and neighborhood standards for project-based vouchers will apply. In addition, the requirements of 24 CFR Part 8 will apply, and specifically address the site selection with respect to accessibility for persons with disabilities.

The Applicant shall ensure that all Assisted Units meet all applicable federal and state property standards. All Assisted Units must also meet the requirements of 25 CCR Section 8304 for the duration of the affordability period. Projects must meet the accessibility requirements specified in the TCAC regulations, as may be amended and renumbered from time to time, including those of Section 10325(f)(7)(K) and, for senior projects, those of Section 10325(g)(2)(B) and (C). Exemption requests, as provided for in the TCAC regulations, must be approved by the Department.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 205. Occupancy and Income Requirements

(a) Household income shall be determined in accordance with the rules in 24 CFR 93.151. At the time of move-in, household income shall not exceed the established extremely low income (ELI) limits or incomes at or below the poverty line, whichever is greater.

(b) The County or subrecipients shall maintain documentation of tenant income eligibility and eligibility in all the following ways, as applicable:

(1) Documentation of enrollment in or eligibility for Medi-Cal benefits.

(2) Documentation of a person's status as Chronically homeless could be captured through any of the following:
   a. A client's entry and exits documented in a Homeless Management Information System;
   b. An outreach worker or Case Manager's written observations; or
   c. A client's self-report of episodes of Homeless and disability status must be done in accordance with procedures established through the local Coordinated Entry System or other procedures established by the County for determining whether a person qualifies as a Homeless and High-cost health user, or Chronically homeless.

(3) Documentation of a person's status as a High-cost health user could be captured through any of the following:
   a. Discharge summaries; or
   b. An outreach worker's, case manager's or local County's health department written observations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 206. Rent Limits

(a) Assisted Unit rent shall not exceed the Fair Market Rent or reasonable market rent as determined by the Department. Tenants must meet the income determination requirements of Section 205.

(b) Over-income tenants - if at the time of re-certification, a tenant household's income exceeds the extremely low-income limit, or income at or below the poverty line, then the County/subrecipient:

(1) Shall re-designate the tenant's Assisted Unit as a non-Assisted Unit and designate the next available non-assisted comparable unit as an Assisted Unit until the unit mix required by the Program regulatory agreement is achieved.

(2) If all the project units are Assisted Units, that project can continue with the over-income unit(s) until such time as those over-income households no longer reside in the project.

(3) A unit shall be deemed "comparable" if it has the same number of bedrooms and reasonably similar square footage as the original unit.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 207. Capitalized Operating Subsidy Reserves (COSR)

HHC grant funds may be used to pay for a COSR with the following conditions:

(a) The COSR shall be sized to cover anticipated operating deficits attributable to the Assisted Units for a minimum of 15 years. The total amount of each project's operating reserves will be determined based upon the individual project underwriting performed by the County pursuant to the requirements of these Guidelines.

(b) In determining how to size each project's COSR, the County shall consider individual project factors, such as: the maximum percentage of Assisted Units it will assist; anticipated project vacancy rates; the anticipated percentage of Assisted Units that will have other operating subsidy and the term of that operating subsidy contract, and anticipated tenant incomes.

(c) The following standard assumptions will be used for establishing the total amount of a COSR. The Department may modify these assumptions as necessary to maintain project feasibility or extend the term of the operating reserves.

(1) All Assisted Units, other than the proportionate share of the manager's unit,

shall be counted in calculating the amount of COSR. An Assisted Unit receiving other rental assistance may receive assistance from a COSR.

(2) In projects of greater than 20 units, HHC will assist no more than 49 percent of the total project units. This limitation shall not be interpreted to preclude occupancy of any project units by persons with disabilities or restrictions by other funding sources, including but not limited to TCAC, that result in more than 49 percent of the total project units being restricted to the Target Population. It shall also not apply to projects complying with alternative requirements for demonstrating Olmstead compliance adopted by local jurisdictions and approved by the Department.

(3) In projects of 20 units or less, up to 100 percent of the units may be Assisted Units.

(4) The stabilized residential vacancy rate for the Assisted Units shall be assumed to be 10 percent, unless use of a lower or higher rate is required by another funding source, including TCAC, or is supported by compelling market or other evidence.

(d) Notwithstanding the above, in order to sustain the availability of a COSR for a minimum of 15 years, distributions from a COSR shall be subject to the following:

The County may not disburse more than 5 percent of the total COSR award made to a project per year, except that in any given year where the operating deficit attributable to the Assisted Units exceeds this amount, the Grantee may, in its sole discretion, increase the disbursement to up to 7 percent of the total COSR award, in accordance with the operating reserves limits and applicable review processes.

(e) Operating expenses that are eligible to be paid from a COSR include:

(1) Insurance

(2) Utilities

(3) Real property taxes

(4) Maintenance

(5) Supportive Services costs

(f) The statute/Guidelines do not preclude use of HHC funds on other supportive housing opportunities using capital and operating assistance, as long as the use of the funds is consistent with the requirements of Part 14.2 of Division 31 of the Health and Safety Code, as well as all other state, federal laws and regulations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 208. Maximum Award Limits

The maximum grant limit is $20,000,000 per Applicant for new construction, acquisition, rehabilitation, rental subsidies, administrative costs and/or operating assistance (COSR and/or rental assistance). The actual award amounts may be adjusted for project size and the number of households served.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 209. Fee Limits

A County may use up to 10 percent of the grant, as reflected in the NOFA, to fund administrative costs for the HHC program.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 210. Use of Operating Cash Flow

Regarding allowable uses of operating cash flow for capital or operating subsidies, including a COSR, the County shall follow the requirements commencing with 25 CCR Section 8314, as applicable.

Where there is a difference between the provisions of the UMRs and these Guidelines, the provisions of these Guidelines shall prevail.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 211. County Application Plan

Any plan that meets the following requirements is acceptable, including, but not limited to, Continuum of Care plans, or any other County plan specific to homelessness. Applicant's proposed uses of funds should be clearly connected to the goals and strategies outlined in the plan.

Applicants should include in their application plan the following:

(a) A description of homelessness County-wide, including a discussion of the estimated number of residents experiencing homelessness or chronic homelessness among single adults, families, and unaccompanied youth;

(b) Special challenges or barriers to serving the Target Population;

(c) County resources applied to address homelessness, including efforts undertaken to prevent the criminalization of activities associated with homelessness;

(d) Available community-based resources, including partnerships with community-based organizations and non-profits;

(e) Identification of other partners tasked with addressing Homeless needs;

(f) Systems in place to collect the data required under Section 219;

(g) Efforts that will be undertaken to ensure that access to a CES, and any alternate assessment and referral system established for the Target Population pursuant to the requirements of these Guidelines, will be available on a nondiscriminatory basis;

(h) Applicants may propose an alternative definition of High-cost health user than defined in Section 201 of these Guidelines.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53592 and 53595.

Section 212. Application Process

(a) The Department shall issue a NOFA that details the application process for Applicants that specifies, among other things, the amount of funds available, application requirements, threshold requirements, award requirements, the allocation of rating points, the deadline for submittal of applications, and other general terms and conditions of funding commitments.

(b) The Department shall evaluate applications for compliance with the minimum requirements set forth in Section 202 and score based on the criteria outlined in Section 213.

(c) Applicants that do not meet the minimum requirements will be rejected and will not be rated.

(d) The Department reserves the right to do the following:

(1) Score an application as submitted in the event information is missing from the application; and

(2) Request clarification of unclear or ambiguous statements made in an application and other supporting documents where doing so will not impact the competitive scoring of the application.

(e) Applications selected for funding shall be approved at amounts, terms, and conditions specified by the Guidelines and the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1).

Section 213. Application Selection Criteria

The criteria detailed below and summarized in the following table shall be used to rate applications.

	Maximum Applicable Points
Need	
Number of individuals experiencing homelessness and impact of housing costs (H&S Code 53591(a)(1)(A)	10
Applicant's commitment to address Homeless needs (H&S Code 53591(a)(1)(D)	15
Total Need Points	**25**
Proposed Uses and Process for Using Funds	
Project(s) Description (H&S Code 53591(a)(1)(F)	10
Process for Using Grant Funds (H&S Code 53591(a)(1)(B)	10
Funding Coordination (H&S Code 53591(a)(1)(C)	10
Total Uses of Funds Points	**30**
Experience	
Applicant's experience in rental subsidies, funding, underwriting, or administering Supportive housing projects	15
Applicant's experience with projects comparable in scope/services to proposed project	15
Barriers encountered and addressed	5
Identify any best practices that could be used by other program participants	5
Total Experience Points	**40**
Funding Sources	
Description of plan to sustain funding	30
Total Funding Sources Points	**30**
Incentive Points	
Applicant has Whole Person Care Pilot Program available or renewed, or has Health Homes Program, or has other County-controlled funding that provides similar services to the Target Population. H&S Code 53591(a)(1)(E)	10
Projects with locally committed funding for projects in an amount at least equivalent to requested HHC funding	10
Total Incentive Points	**20**
TOTAL APPLICABLE POINTS	**145**

(a) Need (25 points maximum)

Consideration will be given to the number of individuals experiencing homelessness and the impact of housing costs in the County. Estimated need will be based on the number of Homeless individuals established at the latest PIT count and rent burden in the Applicant's geographic jurisdiction according to the Comprehensive Housing Affordability Strategy (CHAS) data. Points will be awarded as follows:

(1) Estimated Need (10 points maximum)
   a. More than 400 individuals are Homeless in the Applicant's geographic jurisdiction as stated in the NOFA (10 points); or
   b. More than half of the ELI population in the Applicant's geographic jurisdiction pay more than 50 percent of their income towards rent. (5 points)

(2) Describe the Applicant's demonstrated commitment to address the needs of people experiencing homelessness. Applicant has demonstrated successful outcomes in implementing federal and state programs addressing the needs of people experiencing homelessness, along with local commitment of resources. (15 points maximum)
   a. The Applicant has dedicated local resources to provide Permanent housing to residents experiencing homelessness over the last three years and has a plan to address homelessness. The plan has been successful and has been implemented for at least one year (15 points); or
   b. The Applicant has administered programs with successful outcomes in moving people from homelessness to Permanent housing but has not dedicated resources consistently over the last three years. The Applicant has a plan to address homelessness and has been implementing it over the last year (10 points); or
   c. The Applicant proposes to implement some actions in the next 12 months, including implementation of a plan to address homelessness and dedication of local resources. (5 points)

(b) Proposed Uses and Process for Using Funds (30 points maximum)

(1) Project Description. Applicant's description of the specific uses of the grant funds. For each specific planned use of the grant funds, the Applicant must respond to the required items to receive full points: (10 points)
   a. If the Applicant intends to use funding for development, project(s)' location and target date(s) for completion (10 points); or
   b. If the Applicant intends to use funding for rental assistance or a COSR, project(s)' total number of units and the total number of households who will receive Permanent housing and/or rental subsidies under the project (10 points).

(2) Process for Using Grant Funds. The Applicant's description of the following: (10 points maximum)
   a. The Applicant's or agency or agencies responsible for the distribution of the HHC grant funds and the proposed selection criteria and process to identify project(s) and/or sub-recipient(s) (6 points);

b. The timeline with clearly delineated milestones (1 point); and
c. The proposed funding source for the services (3 points)

(3) Funding Coordination. The Applicant's description of how the proposed HHC funding will supplement existing federal, state, and local funding. (10 points maximum)
a. Regarding service provision, the Applicant's description of the following:
1. The funding source(s) (2 points);
2. The amount of funding per participant, per month, the Applicant intends to commit (1 point);
3. The length of time services will be provided (1 point); and
4. The process for selecting the Homeless service provider (2 points).
b. The description of the Applicant's partnerships with affordable and Supportive housing providers to address homelessness (2 points).
c. The description of the Applicant's partnerships with healthcare providers who provide dental, mental health, primary care and substance abuse services (2 points).

(c) Experience (40 points maximum)

(1) The Applicant's experience, for the last three years, in funding and underwriting Supportive housing projects; and/or the Applicant's experience administering Supportive housing projects; and/or the Applicant's experience working with agencies that administer rental subsidies. (15 points maximum)
a. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered four or more projects in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 500 households in the last three years. (15 points)
b. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered at least two to three projects in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 300 households in the last three years. (10 points)
c. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered one project in the last three years. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 100 households in the last three years. (5 points)

(2) The Applicant's development funding, rental assistance, or other operating assistance to the Target Population that is comparable in scale and scope to the number of projects or rental assistance the Applicant has proposed for the Program. (15 points maximum)
a. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered four or more projects comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance,

the administering agency has administered rental subsidies for at least 500 clients similar to the Target Population. (15 points)

b. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered at least two to three projects comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 300 clients similar to the Target Population. (10 points)

c. If the Applicant intends to use funding for development or a COSR, the Applicant has developed and/or administered one project comparable in scale and scope to the proposed project and Target Population. If the Applicant intends to use funding for rental assistance, the administering agency has administered rental subsidies for at least 100 clients similar to the Target Population. (5 points)

(3) Description of barrier(s) the Applicant encountered in the implementation of its Homeless strategy or funding and how barriers were resolved. (5 points)

(4) Description of any best practices developed by the Applicant that could be used for other program participants. (5 points)

(d) Funding Sources (30 points maximum)

(1) The Applicant's description of the plan to sustain funding for the program/project. The Applicant may commit to using funding from the Building Homes & Jobs Act allocations to score points in this category. (30 points)

(e) Incentive Points (20 points maximum)

(1) The Applicant has a Whole Person Care Pilot Program or is working with managed care organizations to make available Health Homes Program benefits to people experiencing homelessness. (10 points)

(2) Evidence demonstrating locally committed funding in an amount at least equivalent to requested HHC funding. (10 points)

In the event of tied point scores, the following tiebreakers shall be used to determine which project is selected for funding, in the order listed:

(1) Applicant relevant experience

(2) Need

(3) Application Plan

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1).

Section 214. Supportive Services

(a) Each application must include a County-specific Supportive Services plan that will identify how the County plans to provide or subcontract to provide Supportive Services to participants in the Program.

(b) The County must ensure services are provided to participants, but that participants are not required to participate in services. Access to or continued occupancy in housing cannot be conditioned on participation in services or on sobriety. The Supportive Services plan must describe the services to be made available to HHC tenants in a manner that is voluntary, flexible, and individualized, so HHC tenants may continue to engage with supportive services providers, even as the intensity of services needed may change. The level of services should support tenant engagement and housing retention.

(c) Using evidence-based models, the following Supportive Services shall be made available to HHC tenants based on tenant need. Except as otherwise noted below, the following required services shall be provided onsite at the project or offsite at another location easily accessible to tenants, with the majority of case management services offered on-site:

(1) Housing navigation to assist people experiencing homelessness to establish relationships with private landlords, if the County is using funding for rental assistance, and to apply for housing;

(2) Case management and tenancy support services;

(3) Peer support activities;

(4) Services to link participants, as needed, to behavioral health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups and to coordinate care;

(5) Services to link participants, as needed, to substance abuse disorder treatment;

(6) Support in linking to primary care services, including access to routine and preventive health and dental care, medication management, and wellness services;

(7) Benefits advocacy, including assistance or linkage to services in accessing Medi-Cal and Supplemental Security Income/State Supplementary Payment(SSI/SSP);

(8) Housing retention skills, including working with landlords and neighbors, unit maintenance and upkeep, and money management; and

(9) Services for persons with co-occurring mental and physical disabilities or co-occurring mental and substance use disorders not listed above.

The following Supportive Services are not required to be made available but are encouraged to be part of an Applicant's plan to provide Supportive Services to participants.

(1) Recreational and social activities;

(2) Educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process;

(3) Employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work; and

(4) Obtaining access to other needed services, such as civil legal services, or access to food and clothing.

(d) The following additional information shall be provided in the Applicant's plan to provide Supportive Services:

(1) Description of tenant outreach, engagement, and retention strategies to be used;

(2) Description of each service to be offered, how services will be offered or provided depending upon who is anticipated to be providing the services, the location, and general hours of availability of the services;

(3) For services provided off-site, the plan must describe what public or private transportation options will be available to HHC tenants in order to provide them reasonable access to these services. Reasonable access is access that does not require walking more than one-half mile. Case management services should largely be provided on-site;

(4) Description of how the Supportive Services are culturally and linguistically competent for persons of different races, ethnicities, sexual orientations, gender identities, and gender expressions. This includes explaining how services will be provided to HHC tenants who do not speak English, or have other communication barriers, including sensory disabilities, and how communication among the services providers, the property manager, and these tenants will be facilitated;

(5) Estimated itemized budget, and sources of funding for services;

(6) Description of how the supportive services staff and property management staff or landlord will work together to prevent evictions, adopt and ensure compliance with harm reduction principles, and facilitate the implementation of reasonable accommodation policies from rent-up to ongoing operations of the project;

(7) General service provider and property manager communication protocols;

(8) Provider-to-client staff ratio (1:20);

(9) Description of how the physical design of the project fosters tenant engagement, onsite supportive services provision, safety and security, and sustainability of furnishings, equipment, and fixtures; and

(10) Other information needed by the Department to evaluate the Supportive Services to be offered consistent with the program, as specified in the NOFA.

The Department may request that any necessary updates to the plan to provide Supportive Services or related documents, including fully executed written agreements between the County, service providers, the project owner(s), if relevant, and the property manager, if relevant, be provided prior to the beginning of the initial rent-up period or prior to permanent loan closing, or after participants move into private-market apartments.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 215. Housing First

(a) Projects shall employ Housing First practices that are documented in the Applicant's plan to provide Supportive Services in the application. Projects must adhere to the Housing First core components pursuant to Welfare and Institutions Code Section 8255(b).

(b) Housing First practices include the following:

(1) Tenant selection practices that adhere to Section 216 of these Guidelines and promote the acceptance of Applicants regardless of their sobriety or use of substances, completion of treatment, or agreement to participate in services;

(2) Tenants are not rejected on the basis of poor credit or financial history, poor or lack of rental history, or minor criminal convictions;

(3) Tenants are assisted in making application for tenancy and reasonable accommodation requests;

(4) Supportive Services are flexible and voluntary and focus on housing stability, engagement, and problem-solving over therapeutic goals; and

(5) Landlords or property managers do not impose restrictions on daily activities or limiting privacy, visitors, or the individual's ability to engage freely in community activities.

(c) Management and services practices emphasize tenant retention and offer flexibility and services to prevent and resolve lease violations and evictions. Subsidy-only units

shall follow Housing First property management and services practices described in subsection (b) above or implement modified Housing First practices that, at a minimum, incorporate:

(1) Tenant selection practices that promote the acceptance of Applicants regardless of their sobriety or use of substances, completion of treatment, or agreement to participate in services;

(2) Applicants are seldom rejected on the basis of poor credit or financial history, poor or lack of rental history, or minor criminal convictions;

(3) Applicants are assisted in making application for tenancy and reasonable accommodation requests;

(4) Assistance shall be provided in obtaining Permanent housing as rapidly as possible and without preconditions, such as participation in services, length of stay, or successful completion of transitional housing program. Upon exit to Permanent housing, follow up services shall be provided for no less than six months to ensure that tenants retain Permanent housing; and

(d) Services are voluntary unless required by a public agency funding source.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 216. Tenant Selection

(a) Tenants must meet income requirements in Section 205 and Target Population requirements in Section 202.

(b) Tenants shall be selected through use of a CES, in accordance with the provisions of 25 CCR Section 8305 and in compliance with Housing First requirements consistent with the core components set forth in Welfare and Institutions Code Division 8

Chapter 6.5 Section 8255 subsection (b) and basic tenant protections established under federal, state, and local law.

(1) Reasonable selection criteria, as referred to in 25 CCR Section 8305(a)(1), shall include priority status under a local CES developed pursuant to 24 CFR 578.7(a)(8).

(2) If the CES existing in the County cannot refer persons in the Target Population, the alternative system used must prioritize those with the greatest needs among those for referral to available Assisted Units.

(3) Sponsors shall accept tenants regardless of sobriety, participation in services or treatment, history of incarceration, credit, or history of eviction in accordance with practices permitted pursuant to WIC Section 8255 or other federal or state project funding sources.

(c) The requirements of 25 CCR Sections 8305 (a)(4)(A) and 8305 (a)(4)(D) shall be implemented as approved by the Department in a manner that is consistent with the requirements of the CES.

(d) In communities that are not yet referring people experiencing homelessness to programs through CES, Applicants should describe the process of referring residents based on eligibility for the Program.

(e) Projects must also provide a preference for accessible units to persons with disabilities requiring the features of the accessible units in accordance with Section 10337(b)(2) of the TCAC regulations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 217. Rental Agreements and Grievance Procedures

Rental or occupancy agreements and grievance procedures for Assisted Units shall comply with 25 CCR Section 8307 and 24 CFR 93.303. Tenants shall not be required to maintain sobriety, be tested for substances, or participate in services or treatment.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53594.

Section 218. Vulnerable Populations Best Practices

The following best practices should be incorporated in the construction of projects that receive funding from HHC, to the extent possible. These best practices work to further the safety and physical and mental well-being of residents within a project.

(a) General best practices for all developments:

(1) Safety features:
   a. Site selection and development of the project should consider the safety concerns of the prospective tenants.
   b. Building entrance and exit points should only allow admittance to residents or guests that residents admit.
   c. Common areas within the project should be oriented so as to have:
      1. Two ways to enter or exit the area;
      2. Visibility to the area from outside of it, i.e. windows in walls or doors; and
      3. A centralized location, to the extent possible.
   d. Safety lighting that reduces or eliminates blind or dark spaces.

(2) Property Management:
   a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
   b. Post in common areas and annually review with tenants the project's

grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(b) For those populations that have a history of sexual trauma and/or domestic violence:

(1) Safety features incorporate all of the general best practices and include the following:

a. For projects that will also be serving women with a history of domestic violence or sexual trauma:

1. Designate at least 25 percent of the Assisted Units for women with a history of domestic violence or sexual trauma and/or women with children, thereby ensuring women are not a small minority of the tenancy.
2. Design projects to provide separate and secure floors, wings, or buildings for women with a history of domestic violence or sexual trauma and/or women with children. These separate and secure areas should restrict access to only the residents in the secured area.

b. Security cameras:

1. At entrances, exits and common areas (including hallways, elevators, and stair wells);
2. Written policy on the use of the cameras to specify who has access to see the videos, who monitors the surveillance, and under what conditions footage would be released to the authorities; and
3. Camera recordings should be maintained for at least 30 days.

(2) Property Management:

a. Policies to support an on-call staff member or 24-hour availability of staff from the property management company.
b. Post in common areas and annually review with tenants the project's grievance policy. The policy should include procedures for grievances with management staff or contractors and the process by which the tenant may elevate the complaint.

(c) The project should have 24-hour security if it serves persons impacted by domestic violence, transition age youth and other vulnerable populations.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53595.

Section 219. Reporting Requirements

The County shall, at annual and midyear intervals, report all of the following data to the Department:

(a) Not later than 90 days after the end of each project's fiscal year, the Grantee shall submit an independent audit of the development prepared by a certified public accountant and in accordance with the Department's current audit requirements and all other applicable requirements, as stated by law or included in the NOFA.

(b) The County shall submit the data as required by the Department to measure the costs and outcomes for each of its Assisted Units. The County shall work with service providers or other sub-recipients to gather the data.

(c) The County shall report on the sources of tenant referrals for the project and submit both client data and performance outcome data to the Department. Tenant data may include, but is not limited to, demographic information. Performance outcome data shall include, but is not limited to, information on housing stability, tenant satisfaction as measured in a survey, and changes in income and benefits received.

(d) The County shall also report on the following:

(1) The number of participants who have received assistance through the Program in that year, and the type of intervention the participant received with HHC funds;

(2) The number of participants living in Supportive housing or other Permanent housing with HHC funds, and exits from the program, and the reasons for the exits; and

(3) To the extent available and feasible, the County shall provide data on the impact of the Program on participant's use of corrections systems and law enforcement resources.

(e) Recipient must comply with 2 CFR Part 512, as outlined in the NOFA.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53593.

Section 220. Operating Budgets

The County shall submit proposed operating budgets to the Department prior to award and annually thereafter. These budgets shall be subject to Department approval and comply with the requirements in 25 CCR Section 7326.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594.

Section 221. Federal and State Overlays

(a) Federal Overlays. Activities funded with HHC funds are required to comply with 24 CFR Part 93.350 and 24 CFR Part 93.301. Compliance with these requirements include, but are not limited to, environmental provisions, federal Davis-Bacon Wage requirements and state prevailing wage laws, relocation, Equal Opportunity and Fair Housing, Fair Housing Amendments Act, Affirmative Marketing, Section 504 of the Rehabilitation Act and its implementing regulations, and the Americans with Disabilities Act and its implementing regulations, Section 3 (employment of low-income persons), Violence Against Women Act, and Single Audit report 2 CFR Part

200.512. Failure to comply with federal overlays could result in significant project cost increases, and rejection of the HHC application.

(b) State Overlays. Article XXXIV of the California Constitution requires local voter approval before any state public body can develop, construct, or acquire a low-rent housing project in any manner. However, the Public Housing Election Implementation Law (Health & Safety. Code, §§ 37000 – 37002) provides clarification as to when Article XXXIV is applicable.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

Section 222. Legal Documents

Grants shall be governed by a Standard Agreement or other agreement with the County on a form prescribed by the Department. The agreement shall ensure that the provisions of these Guidelines are applicable to the project(s) covered by the agreement and enforceable by the Department. The agreement will contain such other provisions as the Department determines are necessary to meet the requirements and goals of the program, including, but not limited to, the following:

(a) Requirements for the execution of a promissory note, operating reserve agreement, or other project-specific contracts as may be applicable;

(b) Requirements set forth in the NOFA;

(c) Requirements, where appropriate, for the execution and recordation of covenants, regulatory agreements, or other instruments restricting the use and occupancy of and appurtenant to the project and the property thereunder (for the purposes of these Guidelines, all such documents are collectively herein referred to as the HHC regulatory agreement);

(d) The County's responsibilities for timing and completion of Projects, if applicable, as well as any and all reporting requirements;

(e) Remedies available to the Department in the event of a violation, breach or default of the Standard Agreement; and

(f) Any and all other provisions necessary to ensure compliance with the requirements of HHC and applicable state and federal law.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

Section 223. Defaults and Grant Cancellations

In the event the Department becomes aware of a breach or violation by the Grantee or its participating entities engaged in the delivery of HHC, any of the provisions of HHC–SB 2 requirements or Standard Agreement, or the locally executed HHC loan or

grant pertaining to the project, the Department may give written notice to violators to cure the breach or violation within a period of not less than 15 days. If the breach or violation is not cured to the satisfaction of the Department within the specified time period, the Department, at its option, may declare a default under the relevant document(s) and may seek legal remedies for the default, including but not limited to the following:

(a) Termination of the Grant Agreement and full or partial repayment of the awarded amount.

(b) Suspension from future Department funding awards.

(c) The Department may seek other remedies set forth in the Grant Agreement or any other applicable legal or equitable remedies.

If the breach or violation involves charging tenants rent or other charges in excess of those permitted under the Standard Agreement, the Department may demand the return of such excess rents or other charges to the respective households. In any action to enforce the provisions of the Standard Agreement, the Department may seek, as an additional remedy, the repayment of such overcharges.

NOTE: Authority cited: Health and Safety Code Section 53598(b). Reference cited: Health and Safety Code Section 53591(a)(1) and 53594 and 50472.

A Public Agency

CalOptima

Better. Together.

Homeless Health Care Update

Board of Directors Meeting

April 4, 2019

Michael Schrader

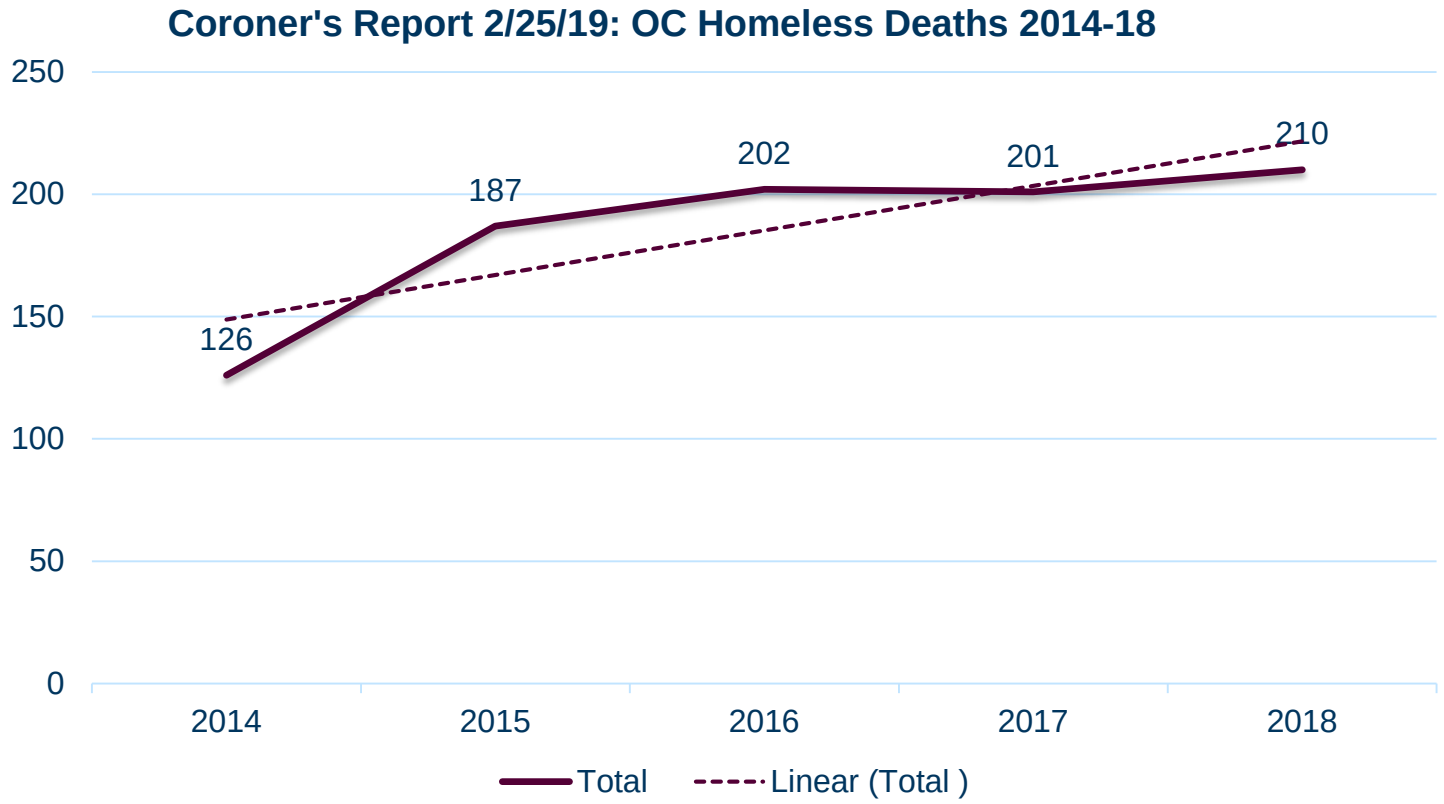
Chief Executive Officer

Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

Coroner’s Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
  - Clinical field teams (CalOptima)
  - CalOptima Homeless Response Team (CalOptima)
  - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
  - Opioid prescribing interventions (CalOptima)
  - Medication-assisted treatment (County and CalOptima)
  - Substance use disorder centers (County)
  - Medical detox (CalOptima)
  - Social model detox (County)
  - Naloxone (County and CalOptima)
  - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
  - Moderate-severe behavioral health (County)
    - Crisis intervention
    - Post-acute transitions
    - Intensive outpatient treatment programs
  - Mild-moderate behavioral health (CalOptima)
    - Screening
    - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee
Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

Ad Hoc Recommendations

- Take action to commit $100 million for homeless health
  - Create a restricted homeless health reserve
  - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$1.2 million	$4.8 million	IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)		$10 million	
New Initiatives		$60 million	
Total Reserve: $100 million	**$25.2 million**	**$74.8 million**	

Clinical Field Team Structure

- Team Components
  - Includes clinical and support staff
  - Vehicle for transportation of staff and equipment
  - Internet connectivity and use of Whole-Person Care (WPC) Connect
- Clinical Services
  - Urgent care, wound care, vaccinations, health screening and point-of-care labs
  - Prescriptions and immediate dispensing of commonly used medications
  - Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
  - Coordination with CalOptima Homeless Response Team
  - Coordination with providers
  - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
  - Regular hours at shelters/hot spots
  - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
  - AltaMed
  - Central City Community Health Center*
  - Hurtt Family Health Clinic*
  - Korean Community Services*
  - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
  - Deploy on a phased basis, based on FQHC readiness

** Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
  - Available to Blue Shirts and CHAT-H nurses
  - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
  - Establish working in-person relationships with collaborating partners
  - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
  - Maximum flexibility with access to any provider (no PCP assignment)
  - Fast-tracked authorization processing
  - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
  - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
  - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
  - $2 million financial impact per year
  - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
  - Reallocate $250,000 of the $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
  - Leverage existing process
    - County to coordinate and pay recuperative care vendor
    - CalOptima to reimburse County for 100 percent of cost
  - COBAR in April
  - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
  - Specifically used for homeless individuals
  - Includes social supports and referrals to services
  - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
  - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
  - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
  - Case management staff is trained and actively uses the system
    - Identify members enrolled in WPC
    - Coordinate with other partners caring for members
    - Access information from other partners

- Status of WPC Connect
  - Five hospitals are currently connected
  - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
  - Regulatory and legislative
  - Available permanent supportive housing and shelters
  - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
  - Enrollment assistance
  - Enhanced data connectivity technology
  - Housing supportive services
  - Other physical health services
  - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
  - Clinical field team implementation
  - Medical respite program
  - Homeless coordination at hospitals

- Additional action recommended by Board Ad Hoc
  - Create a restricted homeless health reserve in the amount of $100 million
    - $24 million – previously approved initiatives using IGT 1–7 funds
    - $76 million – all IGT 8 funds (approximately $43 million) with balance from FY 2018–19 operating funds
  - Stipulate that funds can only be used for homeless health

CalOptima's Mission

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


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

Medi-Cal CalOptima
A Public Agency
Better. Together.

December 4, 2020

AFH Casa Paloma LP
c/o Myles A. Peinemann II, Chief Executive Officer
American Family Housing
15161 Jackson Street
Midway City, CA 92655

RE: Housing for a Healthy California Program (HHC)
Casa Paloma Permanent Supportive Housing Development

To Whom It May Concern:

Orange County Health Authority, dba CalOptima, the county organized health system for the County of Orange, California ("CalOptima") is the county's Medi-Cal managed care plan. Pursuant to its contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), CalOptima arranges and pays for the provision of covered health care services ("Covered Services") to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program"). CalOptima also contracts with DHCS to arrange and pay for Health Homes Program (HHP) services.

On or about August 8, 2019, CalOptima submitted a letter of commitment in support of AFH Casa Paloma LP's ("Property Owner") application under Article I of the Housing for a Healthy California Program ("Application"). Property Owner and American Family Housing ("Developer" and "Lead Service Provider") (jointly referred to herein as "AFH") have advised that the California Department of Housing and Community Development (HCD) has awarded funding under HHC for development of Casa Paloma, a property in the County of Orange (the "Development"). The Development will include 69 affordable housing units of which 48 will be permanent supportive housing; 34 of these permanent supportive housing units will be funded under HHC. The Casa Paloma project construction is expected to start in March 2021 and to be completed in May 2022.

CalOptima reiterates its commitment to provide Covered Services consistent with its obligations under its DHCS Contract with respect to residents enrolled in CalOptima's Medi-Cal Program and, as applicable, its HHP.

CalOptima's commitment assumes the following conditions are met for the residents who will occupy the 34 permanent supportive housing units funded under HHC in the Development:

- 100% of these residents will voluntarily participate in services set forth in Section 112(c) of the HHC Guidelines.
- 100% of these residents will be enrolled in CalOptima's Medi-Cal program at the beginning of tenancy at the Development.

- 60%, or 20.4 of these residents will be enrolled in the HHP, which is available only to CalOptima Medi-Cal members meeting HHP eligibility criteria as defined by DHCS and who choose to participate in HHP at the beginning of tenancy at the Development.
- All required or optional services set forth in Section 112(c) of the HHC Guidelines, and not specifically covered by CalOptima Medi-Cal and/or HHP for its enrolled members under its DHCS Contract, will be provided by or through the Lead Service Provider.

Based on the above assumptions, the collective commitment from CalOptima based on Medi-Cal Covered Services and HHP services is an estimated amount per resident per year broken down as follows:

- 34 residents will be enrolled in CalOptima Medi-Cal program ($93.26 per resident per year)
- 20.4 residents will also be enrolled in HHP ($354.75 per resident per year) in addition to the above.

Supportive services will be provided to eligible CalOptima Medi-Cal members on a voluntary basis. Based on these assumptions, the value of this commitment in a 12-month period, is $124,892.88, which will be provided as Covered Services through CalOptima Medi-Cal and/or HHP for its enrolled members. If the number of individuals enrolled in CalOptima or its HHP is higher, the value would increase, or if lower, the value would decrease.

It is CalOptima's intent to assist AFH at the Development with Covered Services through Medi-Cal and/or HHP for CalOptima members in the 34 permanent supportive housing units under HHC. CalOptima and AFH will collaborate to ensure CalOptima members receive the needed Covered Services. This may include, for example, calls, emails, attending and/or convening periodic meetings with AFH directly or through AFH partners to coordinate care and/or problem-solve around:

- Health care needs for CalOptima members;
- Covered services and support needed for CalOptima members to remain housed and stable; and,
- General tenant, building and community issues to support the needs of CalOptima members.

If you have any questions, please do not hesitate to contact Debra Kegel, Director Strategic Planning at 714-347-5763.

Sincerely,

Richard Sanchez
Chief Executive Officer

RS:dk

cc: Ladan Khamseh, Chief Operating Officer
Rachel Selleck, Executive Director Public Affairs
Candice Gomez, Executive Director Program Implementation
Debra Kegel, Director Strategic Planning

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MEMORANDUM OF UNDERSTANDING

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA CALOPTIMA

AND

AMERICAN FAMILY HOUSING

This Memorandum of Understanding ("MOU") is made and entered into as of this [Day] of [Month], [Year], by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and American Family Housing ("AFH"), a California nonprofit public benefit corporation. CalOptima and AFH may be referred to individually as "Party" and collectively as "the Parties".

RECITALS:

A. CalOptima is a local public agency which, by statute, has the responsibility of operating a County Organized Health System for Orange County, California. Pursuant to its contract with the State of California, Department of Health Care Services ("DHCS"), CalOptima coordinates the provision of covered health care services ("Covered Services") to Orange County Medi-Cal beneficiaries using managed care principals.

B. AFH is the Managing Member of AFH Casa Paloma GP LLC, and a Managing General Partner of AFH Casa Paloma LP ("Casa Paloma"). In 2020, the California Department of Housing and Community Development ("HCD") awarded funding to AFH under the Housing for a Healthy California Program ("HHC") for the development of Casa Paloma, a property located in the County of Orange at 15161 Jackson Street, Midway City, California 92655. AFH is the developer of the property and the development's Lead Service Provider that has the overall responsibility for the provisions of Supportive Services at Casa Paloma.

C. Casa Paloma is a seventy-one (71) unit affordable housing community that is expected to be ready for occupancy on or after May 1, 2022. It is anticipated that most households will consist of individuals; however, households with more than one individual may qualify. Thirty-four (34) of the total units shall be Supportive Housing for tenants who are recipients of or eligible for health care provided through Medi-Cal program. These Supportive Housing units shall be restricted under the HHC program to persons who are chronically homeless and persons that are homeless who are frequent users of the health care system. The intent of this housing community is to allow individuals experiencing significant barriers to housing stability to benefit from Supportive Housing opportunities while decreasing their utilization of emergency departments, in-patient care, and nursing home stays.

D. The purpose of this MOU between AFH and CalOptima is to set forth the manner in which their respective services shall be coordinated for CalOptima Medi-Cal Members that are residing at Casa Paloma.

NOW, THEREFORE, the Parties acknowledge as follows:

I. TERM

A. The term of this MOU shall commence on the actual move-in date that has been set for the first CalOptima Medi-Cal Member that shall reside at Casa Paloma, and continue year to year, unless otherwise terminated earlier pursuant to Section VI of this MOU.

II. DEFINITIONS

A. "Chronically homeless" has the same meaning as in Part 91.5 and 578.3 of Title 24 of the Code of Federal Regulations, except that people who were Chronically homeless before entering an institution would continue to be defined as Chronically homeless before discharge, regardless of length of stay, as those parts read on January 1, 2018.

B. "Homeless" has the same meaning as in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018.

C. "Housing for a Healthy California Program" or "HHC" means the program administered by the California Department of Housing and Community Development to create Supportive Housing opportunities through competitive grants to counties and developers. Pursuant to the 2019 Notice of Funding Availability, the intent of this program is to allow individuals experiencing significant barriers to housing stability to benefit from supportive housing opportunities while decreasing their utilization of emergency departments, inpatient care, and nursing home stays.

D. "Lead Service Provider" means AFH, which is the organization identified in AFH's HHC application that has the overall responsibility for the provisions of Supportive Services and implementation of the Supportive Services plan.

E. "Supportive Housing" means housing with no limit on length of stay, that is occupied by the Target Population and that is linked to onsite or offsite services that assist the Supportive Housing resident in retaining the housing, improving his/her health status, and maximize his/her ability to live, and when possible, work in the community.

F. "Supportive Services" means social, health, educational, income support and employment services and benefits, coordination of community building and educational activities, individualized needs assessment, and individualized assistance with obtaining services and benefits.

III. POPULATION TO BE SERVED

A. The Target Population served under this MOU will be CalOptima Medi-Cal Members who are residents of Casa Paloma including those who are:

1. Chronically homeless or are homeless and are also high-cost health care users upon initial eligibility;

2. Eligible for Supplemental Security Income;

3. Eligible to receive services under a program providing services promoting housing stability; and

4. Likely to improve his or her health conditions with Supportive housing.

B. The Casa Paloma tenants are anticipated to have a range of special needs and may be users of acute inpatient care, have co-occurring mental illness and substance use, and/or medical conditions.

C. At the time of move-in, tenants qualifying for the program will have a household income that will not exceed the established Extremely Low Income (ELI) limits, which is 30% of the Area Median

Income.

IV. CALOPTIMA RESPONSIBILITIES

A. CalOptima shall have the following responsibilities:

1. Collaborate with AFH to ensure that CalOptima's Medi-Cal Members residing at Casa Paloma, receive medical and/or behavioral health services and supports that are needed, to the extent the services are Covered Services under CalOptima's Medi-Cal program, as required under its contract with DHCS, and as provided in accordance with CalOptima policies and guidelines.

2. Refer potential tenants to AFH for assessment to determine if CalOptima Medi-Cal Members meet eligibility to become Casa Paloma tenants. Upon Member's authorization, and as mutually agreed to by both parties to the extent permitted by law, CalOptima shall provide necessary medical documentation to AFH to assist with medical eligibility determination for CalOptima Medi-Cal Members.

V. AFH RESPONSIBILITIES

A. AFH shall have the following responsibilities:

1. Through collaboration with CalOptima, assist CalOptima Medi-Cal Members residing at Casa Paloma with accessing medical and/or behavioral health services and supports that are needed in order to remain housed and stable at Casa Paloma, to the extent the services are Covered Services under CalOptima's Medi-Cal program, as required under CalOptima's contract with DHCS, and as provided in accordance with CalOptima policies and guidelines.

2. Establish tenant selection criteria which specifically outlines the process for determining medical, financial, and residential eligibility for potential tenants, initially and on an annual basis, consistent with all requirements for tenancy at Casa Paloma, based on evaluation of the provided documentation obtained from the CalOptima Medi-Cal Member and as otherwise permitted hereunder, CalOptima. Such procedures may be revised intermittently as needed. A copy of the selection criteria shall be provided to CalOptima prior to execution of this MOU and upon subsequent revisions.

3. Provide housing retention skills such as household maintenance, nutrition and cooking, and ensure access to basic needs such as food and clothing.

4. Provide community building and leadership development activities, including peer facilitated or self-help groups and social/recreational activities, whereby tenants learn, and improve their social skills, life skills, self-esteem, and therefore increase their self-determination and independence.

5. Facilitate introductions between tenants and the local neighborhood watch and community groups, advisory boards, community centers, recreation centers, and community-based organizations and encourage tenants to seek out community organizations and peer-supported activities that interest them.

6. Provide all required or optional services set forth in Section 112 (c) of the HHC Program Guidelines, and not covered by CalOptima Medi-Cal for its enrolled members under CalOptima's DHCS Contract.

7. Ensure that all CalOptima Medi-Cal members residing at Casa Paloma receive a comprehensive intake assessment and Housing Stabilization Plan/ Individualized Service Plan upon move-in that will be reviewed at least every three (3) months and update at least every six (6) months. A copy of the comprehensive intake assessment and Housing Stabilization Plan/ Individualized Service Plan shall be provided to CalOptima upon request on an ad hoc basis and when updated subject to any applicable law and Member consent requirement.

8. Notify CalOptima when a CalOptima Medi-Cal Member's application for tenancy at Casa Paloma has been approved and provide expected move-in date.

9. On a monthly basis, provide CalOptima with a list of all CalOptima Medi-Cal Members that are residing at Casa Paloma, as well as a list of CalOptima Medi-Cal members that no longer reside at Casa Paloma.

VI. TERMINATION

A. Either Party may terminate this MOU without cause upon thirty (30) days prior written notice to the other Party.

VII. CONFIDENTIALITY OF MEMBER INFORMATION

A. AFH agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. AFH further agrees:

1. Health Insurance Portability and Accountability Act (HIPAA). AFH shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. AFH shall comply with HIPAA requirements as currently established in CalOptima Policies.

2. Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, AFH shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of this MOU and pertaining to CalOptima Medi-Cal Members.

3. Declaration of Confidentiality. If AFH and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, AFH 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, and/or CMS, as applicable.

B. The provisions of this section shall survive the termination of this MOU.

VIII. INSURANCE AND INDEMNIFICATION

A. During performance hereunder, and entirely at each Party's sole expense, each Party shall maintain and provide evidence of comprehensive general liability, errors and omission, and automobile liability insurance and Worker's Compensation insurance with limits established and required by the State of California. The Parties shall not of their own initiative cause such

insurance to be canceled or materially changed during the term of this MOU. Each Party shall furnish to the other Party, broker-issued certificate(s) of insurance showing the required insurance coverage upon request.

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

C. The provisions of this section shall survive the termination of this MOU.

IX. LIAISONS

A. AFH and CalOptima shall each designate a liaison to be the primary point of contact for coordination of services under this MOU.

X. MISCELLANEOUS

A. This MOU may only be revised, modified or changed by an amendment in writing signed by both parties.

B. If any provision or any part of this MOU is for any reason held to be invalid and or unenforceable or contrary to public policy, law or statue and/or ordinance, the remainder of this MOU shall not be affected thereby and shall remain valid and fully enforceable.

C. All notices, requests, and other communications under this MOU shall be in writing and mailed to the proper address as follows:

To: Director of Contracting
CalOptima
505 City Parkway West
Orange, CA 92868

To: Myles Peinemann II, Chief Executive Officer
American Family Housing
15161 Jackson Street
Midway City, CA 92655

D. This MOU contains the entire agreement of the Parties with respect to the matters covered hereby, and supersedes any oral or written understandings or agreements between the Parties with respect to the subject matter of this MOU. No person or Party is authorized to make any representations or warranties except to as set forth herein, and no agreement, statement representation or promise by any party hereto that is not contained herein shall be valid or binding. The undersigned acknowledges that she/her has not relied upon any warranties, representations, statements or promises by any of the Parties herein or any of their agents or consultants except as may be expressly set forth in this MOU.

E. The Parties acknowledge that they are acting as independent contractors under this MOU and, except as specifically provided herein, not as a joint venturer, alter ego, agent, employee, or partner of the other Party. Each Party agrees to be solely responsible for all matters relating to

compensation of its employees, including, but not limited to, compliance with laws governing workers' compensation, Social Security, withholding and payment of any and all federal, state and local personal income taxes, disability insurance, unemployment, and any taxes for such persons, including any related employer assessment or contributions required by law, and all regulations governing such matters, and the payment of all salary, vacation and other employee benefits.

F. This is a non-exclusive relationship between CalOptima and AFH. CalOptima shall have the right to enter into similar arrangements with one or more parties as it deems appropriate.

G. The Parties shall observe and comply with federal, state, and local laws relating to the terms of this MOU and in effect when this MOU is signed or which may come into effect during the term of this MOU.

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

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

IN WITNESS WHEREOF, the Parties have, by their duly authorized representatives, executed this Agreement, to be effective the date first written above:

FOR AFH:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
Myles A. Peinemann II	Michael Hunn
PRINT NAME	PRINT NAME
Chief Executive Officer	Interim Chief Executive Officer
TITLE	TITLE
_____	_____
DATE	DATE

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

7. Authorization to execute a contract amendment for updated rates related to the CalOptima Multipurpose Senior Services Program (MSSP) Non-Medical Ancillary Fee-For-Service Contract with Kenady Corporation, dba LifeSpring Nutrition for MSSP Home Delivered Meals

Contacts

Richard Helmer, Interim Chief Medical Officer, 714-246-8400
Kelly Giardina, Interim Executive Director, Clinical Operations, 657-900-1013

Recommended Action

Authorize the Chief Executive Officer (CEO), to execute an amendment to the Multipurpose Senior Services Program (MSSP) non-medical ancillary Fee-For-Service (FFS) provider contract with Kenady Corporation, dba LifeSpring Nutrition, to reflect updated rates, effective March 1, 2022

Background

CalOptima currently contracts with ancillary provider types to provide covered, non-medical services on a FFS basis to CalOptima members enrolled in the MSSP. These contracts are extended to providers who successfully meet all CalOptima credentialing and participation requirements per policy.

For those MSSP program providers of non-medical covered services whose rates are not represented in the published Department of Health Care Services Medi-Cal or Centers for Medicare & Medicaid Services fee schedules, CalOptima has historically utilized varying rates within provider categories at different periods of time. CalOptima MSSP staff has consulted with other MSSP sites within the Southern region of the State that provide home-delivered meal services and has determined that CalOptima's MSSP costs for home-delivered meals are at the lowest range, resulting in the need to adjust non-medical ancillary provider services rates with LifeSpring Nutrition to maintain and expand access to these services.

Discussion

CalOptima management seeks to ensure continued access for MSSP members to a comprehensive network of non-medical ancillary providers of covered services, allowing these members to remain safely in their homes. The services provided by non-medical ancillary providers include:

- Personal care and homemaker services
- Delivered meals
- Emergency response equipment
- Repair technicians to install and repair equipment needed to aid disabled members

In support of CalOptima's non-medical ancillary network, staff believe it is necessary to update reimbursement rates for LifeSpring Nutrition in order for it to continue providing home-delivered meals. Using prior period claims data to forecast overall utilization and claims expenses, and factoring in COVID-related cost inflation for food, fuel and staffing, LifeSpring has requested an increase to its reimbursement rates for home delivered meals to help support the services they are providing to our MSSP participants. In response to this request, as part of the recommended action, staff requests authority

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to update reimbursement terms in CalOptima's contract with LifeSpring to reflect updated rates that align with other MSSP sites in the Southern California region.

Fiscal Impact

The estimated annual fiscal impact for the revised reimbursement rates is $2,500 or 24.6%. The projected Fiscal Year (FY) 2021-22 fiscal impact is approximately $800 for the four-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the MSSP program in the current fiscal year will be sufficient to support the additional costs.

Management will include expenses related to the revised reimbursement rates in future operating budgets.

Rationale for Recommendation

The rates in the non-medical ancillary provider's contract have remained the same since the contract began in January 2003. Based on this factor, coupled with the current inflationary environment, management recommends increasing the rates for CalOptima's MSSP non-medical ancillary provider LifeSpring Nutrition to help ensure continued access to diet-specific meals for CalOptima's MSSP members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. LifeSpring Nutrition Contract Amendment

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kenady Corporation, dba LifeSpring Nutrition	874 W. 16th St.	Newport Beach	CA	92663

AMENDMENT 3 TO
ANCILLARY SERVICES CONTRACT
NON-MEDICAL PROVIDER

THIS AMENDMENT 3 TO THE ANCILLARY SERVICES CONTRACT NON-MEDICAL PROVIDER ("Amendment 3") is effective as of **March 1, 2022**, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and Kenady Corporation, dba **LifeSpring Nutrition** ("Provider"), with respect to the following facts:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract Non-Medical Provider ("Contract"), by which Provider has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Provider desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Attachment C "Compensation" shall be deleted in its entirety and replaced with the new Attachment C – Amendment 3 "Compensation" attached herein.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment 3, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment 3.

FOR PROVIDER:	FOR CALOPTIMA:
Signature	Signature
	Andrew Do
Print Name	Print Name
	Chairman of the Board
Title	Title
Date	Date

DRAFT

ATTACHMENT C – AMENDMENT 3

COMPENSATION

Effective Date: March 1, 2022

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Medi-Cal Program Reimbursement
Not Applicable

II. Medicare Advantage (OneCare) Program Reimbursement
Not Applicable

III. PACE Program Reimbursement
Not Applicable

IV. Cal MediConnect (OneCare Connect) Program Reimbursement
Not Applicable

V. MSSP Program Reimbursement
For MSSP Members, CalOptima shall reimburse for Covered Services as follows:

Service Code: 7.2
Unit Type: Meal
Nutritional Services Home Delivered Meals

MEAL PLAN NUMBER	MEAL PLAN DESCRIPTION	COST PER MEALPLAN
1	14 Meals and Snack -One Per Day	$111.30
2	22 Meals and Snack -One Per Day	$174.90
3	30 Meals and Snack -One Per Day	$238.50
4	40 Meals and Snack -One Per Day	$255.00
5	60 Meals and Snack -One Per Day	$380.00

Meal services include toll-free customer service, home delivery: once (1) per month for the fourteen (14) meal plan, twice (2) per month for all other meal plans. All meal plans include choice of frozen entrée or soup, and a snack.

Invoicing
Provider shall submit to CalOptima an accurate, complete, descriptive, and timely invoice that includes, but is not limited to, Member Name, Member identification number, description of services, and date(s) of service. An invoice may not be submitted before the delivery of service. Provider agrees to submit invoice to CalOptima within fifteen days after the end of the month in which the authorized services were provided. Invoices not submitted within ninety (90) days after the service is rendered are not payable. Provider agrees to submit invoices to CalOptima MSSP via secure e-mail to MSSPinvoices@caloptima.org or via mail to the following address: CalOptima- MSSP Department, Attention: Invoice, 505 City Parkway West, Orange, CA, 92868.

Upon receipt of a clean invoice, CalOptima shall pay Provider within 30 days.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

8. Authorize Amendment to Contract with Kenady Corporation, dba LifeSpring Nutrition, to Support CalOptima Program of All-Inclusive Care for the Elderly (PACE) Home-Delivered Meals

Contacts

Richard Helmer, MD, CMO Interim, 657-933-1823
Monica Macias, LCSW, PACE Director, 714-468-1077

Recommended Action

Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to the contract with Kenady Corporation, dba LifeSpring Nutrition, for PACE home-delivered meals to revise reimbursement rates, commencing June 1, 2022, and extend the contract for an additional year through May 31, 2023.

Background

LifeSpring has been CalOptima PACE's meal provider since PACE opened its doors in 2013. The current contract LifeSpring covers congregate meals at the PACE center as well as home delivered meals to participants who are not able to cook or need support with their special diets. The contract currently runs through May 31, 2022. Due to the COVID-19 pandemic and the day center not fully operating, home delivered meals have been the primary source for many of our PACE participants' nutritional intake. LifeSpring has continued to provide ongoing services such as delivering meals, meeting nutritional and dietary needs, which includes puree diets. On average, LifeSpring delivers over 3,000 meals to our participants per month. LifeSpring provides the following services:

- Delivery
- Puree diets
- Emergency Meal delivery service
- Culturally sensitive meals
- Both Congregate and home meals
- Fresh Congregate meals

Due to COVID cost inflation with food, gas, and staffing, LifeSpring is asking for an increase to their home delivered meals reimbursement to help support the services they are providing to our PACE participants. Currently, the rate for one home delivered meal is $7.00, they are requesting that it be increased to $7.95 per meal.

Discussion

Authorizing the contract extension and rate increase will continue to support PACE's home-delivered meal program, ensuring that there is no gap in services and nutritional needs will continue to be met. CalOptima staff is seeking authority to continue to work with LifeSpring as the meal vendor for the

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PACE program as its commitment to serve PACE participants and ability to increase meal satisfaction for the program has been extremely valuable.

Fiscal Impact

The estimated annual fiscal impact for the revised reimbursement rates is $36,000 or 13.6%. The projected Fiscal Year (FY) 2021-22 fiscal impact is approximately $3,000 for the one-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the PACE program in the current fiscal year will be sufficient to support the additional costs.

Management will include expenses related to the contract extension for the period of July 1, 2022, through May 31, 2023, in the CalOptima FY 2022-23 Operating Budget.

Rationale for Recommendation

Increasing the home delivered meal rate from $7.00 to $7.95 per meal will allow the contracted meal provider to continue to meet the nutritional needs of CalOptima PACE Members in line with their medical conditions in the face of significant cost inflation resulting from the COVID-19 pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. LifeSpring Nutrition – Base Contract for PACE
2. Amendment to LifeSpring Contract

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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Contract Summary Transmittal Form

Provider(s):	Kenady Corporation dba **LifeSpring Nutrition** 872 W. 16th St. Newport Beach, CA 92663 Ph: 949-833-2920 Fx: 949-833-2924 Email: kerryj@susanshealthygourmet.com
Provider Contact Information:	None
Contract ID	C10930490AA
TIN	943296971
NPI Type 1	N/A
NPI Type 2	1205164837
Contract Group Type	Facility
Contract Service Category	Ancillary - Non-Medical
Type of Provider:	Ancillary Non-Medical
Specialty	Meals
Additional Specialty [Secondary, Mixed Group, etc.] (if applicable)	N/A
Line of Business:	PACE
Type of Document:	Contract
FDR Packet Notification: (for delegated or non-healthcare provider)	No
Credentialing Completed by QI: (for new contracts only) Date:	Yes 10/18/2018 - 10/18/2021
NetworX Agreement Pricing Code:	
Medi-Cal	N/A
Medi-Cal Expansion [MCE]	N/A
OneCare Connect [OCC]	N/A
OneCare [OC]	N/A
PACE	RFP
MSSP	N/A
Contract Rate Type	Unique Rate
Payment Type	Fee For Service (FFS)
Payment Method	Finance/ Accounting
Vendor PO Number	17-10052-005 for Home Delivered; 18-10044-004 for Congregate
Effective date of Initial Agreement:	June 1, 2020
Termination date of Agreement:	5/31/2022 w/ 3 1-year term option to renew upon Board approval
Contract Justification:	LifeSpring Nutrition was awarded with the PACE Meals contract by the Board. RFP 20-026
Financial Justification:	Unique rates approved by PACE/Purchasing Dept.
Negotiator:	Peter Obsequio
Date:	June 3, 2020
File path for scanned contract/ amendment: In Contracts Read Only [R-Drive] and In McKesson - [Contract ID: C10930490AA; See Contract PDF or Contract Scanned Image under the Signature Info Tab	
File path for credentialing documentation (new contracts only): G:\Contract Status\Credentialing	

ANCILLARY SERVICES CONTRACT
NON-MEDICAL PROVIDER

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and Kenady Corporation, dba **LifeSpring Nutrition** ("Provider"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), to operate a Medicare Advantage ("MA") plan pursuant to Title II of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-73) ("MMA"), and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program"). CalOptima, as a dual-eligible Special Needs Plan (dual SNP), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services (DHCS).

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract").

E. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

F. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

G. CalOptima has entered into an agreement with the California Department of Aging to operate as a program site under the Multipurpose Senior Services Program ("MSSP"), a case management program with the goal of avoiding or delaying inappropriate placement of persons in nursing facilities, while fostering independent living in the community, as provided by Welfare and Institutions Code section 9560 et seq. As a program site, CalOptima is responsible for arranging for MSSP services for certain CalOptima members.

H. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract

1.1 "Cal MediConnect" means a program to furnish health care services to Medicare/Medi-Cal members who are enrolled in CalOptima's Cal MediConnect Program. Cal MediConnect is also referred to as OneCare Connect.

1.2 "California Children 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 "California Children's Services (CCS) Eligible Condition(s)" means a physically handicapping condition defined in Title 22 CCR Section 41515.2 – 41518.9.

1.4 "CCS Providers" or "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.

1.5 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.6 "CDA" means the California Department of Aging.

1.7 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.7.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

1.7.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.8 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.9 "CalOptima Programs" means the Medi-Cal, OneCare, Multipurpose Senior Service Program (MSSP), Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.10 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.11 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.12 "Clean Claim" means a Claim or invoice that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.13 "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 as their medical home, and their care is coordinated through the PCP.

1.14 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.15 "Covered Services" means those items and services available to Members set forth in Attachment A of this Contract.

1.16 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.17 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The Encounter Data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

1.18 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC, and their respective agents and contractors, including quality improvement organizations (QIOs).

1.19 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.20 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.21 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.22 "Licenses" means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.23 "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).

1.24 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.25 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Enrollee or Participant depending on the CalOptima Program.

1.26 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.27 "MSSP" means Multipurpose Senior Services Program, as provided by W&I section 9560 et seq.

1.28 "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.

1.29 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.30 "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.

1.31 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the enrollee's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a. All Medicare-covered items and services

b. All Medi-Cal covered items and services; and

c. Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

1.32 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.33 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

1.34 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 In accordance with Section 2.20 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.9 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.10 Disclosure of Provider Ownership. Provider shall complete Attachment D and provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing

board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.11 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

2.12 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.13 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 Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.14 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials in the threshold languages identified by CalOptima at no higher than the sixth (6th) grade reading level.

2.15 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as

necessary to ensure effective communication regarding arranging for the provision of non-medical services treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.16 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.17 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Provider and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its

books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or Provider. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or Provider 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.

2.18 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed, or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.19 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.20 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital

status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.21 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with the requests from Government Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.22 Subcontracting of Covered Services. Provider shall not subcontract for any Covered Services without the prior approval of CalOptima. Any subcontracting approved by CalOptima is subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.22.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.22.2 An agreement to maintain such books and records: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.22.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.22.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other customers.

2.22.5 An agreement to comply with CalOptima's Compliance Program.

2.22.6 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.23 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.24 Participation Status. Provider shall have policies and procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

2.24.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.24.2 Provider shall immediately disclose to CalOptima, including but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.24.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

2.24.4 Provider shall include the obligations of this Section in its Subcontracts.

2.24.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.25 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be reviewed to confirm that required Licenses and other applicable qualifications are met. to the extent required by CalOptima Policy.

2.26 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.28 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.29 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.30 Facility Construction or Repair. When applicable for purposes of construction or repair of facilities, Provider shall comply with the provisions in the following acts and/or will include such provisions in any applicable Subcontracts:

- Copeland "Anti-Kickback" Act (18 USC 874, 40 USC 2760) (29 CFR, Part 3)
- Davis-Bacon Act (40 USC 276a-7) (29 CFR, Part 5)
- Contract Work Hours and Safety Standards Act (40 USC 327-330) (29 CFR, Part 5)
- Executive Order 1126 of September 14, 1965 entitled, "Equal Employment Opportunity" as amended by Executive Order 11375 of October 13, 1967, as supplemented in Department of Labor Regulations (41 CFR, Part 60).

When Provider's agreement provides funding for both construction and non-construction activities, Provider shall obtain prior written approval from CalOptima before making any fund or budget transfers between construction and non-construction.

2.31 Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

2.31.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

2.31.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

2.31.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

2.31.1.3 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 Sub provision 13.1.2 herein; and

2.32.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

2.33.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

2.34.1.6 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.

2.31.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

2.31.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

2.31.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

2.32 Lobbying Restrictions and Disclosure Certification. Provider shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in this Addendum E.

2.32.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of

the 31, U.S.C.)

2.32.2 Certification and Disclosure Requirements

2.32.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment E, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 2.30.3 of this provision.

2.32.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment E-1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 2.30.3 of this provision if paid for with appropriated funds.

2.32.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 2.30.2.2 herein. An event that materially affects the accuracy of the information reported includes:

2.32.2.3.1 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;

2.32.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

2.32.2.3.3 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.

2.32.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 2.30.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

2.32.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 2.30.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

2.32.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2.33 Provider's Agent's Qualifications. Provider shall verify the qualifications of all Provider's Agents providing services under this Contract consistent with the services to be provided, as further described in the attached "scope of Work." In addition, for Provider's Agents that enter into Members' homes or have face-to-face contact with Members, Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. Provider shall comply with all applicable laws in conducting background investigations, and shall exclude unqualified Agents from providing services under this Contract.

2.34 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to CalOptima Health

Networks the same terms regarding Provider performance, duties and obligations and rates for Ancillary Services provided to CalOptima Members enrolled in Health Networks as are set forth in this Contract, and to extend to the County of Orange the same terms regarding Provider performance, duties and obligations, and rates for Ancillary Services as are set forth in this Contract.

2.35 Whole Child Model Program Compliance. If Provider is a CCS authorized provider, then in the provision of CCS Services to CalOptima Members, the 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.

2.36 CCS Provider Compliance.

2.36.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.36.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.36.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.36.2.2 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.

2.37 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.38 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.39 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim or invoice, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C.

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies Procedures as may be amended from time to time.

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 or invoices for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.5.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.5.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract.

4.5.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.5.4 Upon receiving notice of Provider invoicing or balance billing a Member for Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.5.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.6 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

4.6.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.6.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Insurance Requirements

5.2.1 Professional Liability:

If providing Professional Services under this contract, the Provider at its sole cost and expense, shall maintain a Professional Liability Insurance policy covering itself and any Subcontractors with minimum limits as follows:

Professional Liability providing Covered Services: $1,000,000 per incident/$2,000,000 aggregate

5.2.2 Commercial General Liability/Commercial Automobile Liability:

Provider, at its sole cost and expense shall maintain a Commercial General Liability and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability: $1,000,000 per occurrence/$2,000,000 aggregate

(Including Personal Injury)

Commercial Automobile Liability: * $1,000,000 Combined Single Limit

Additional insured wording is required on both policies as well as primary and non-contributory wording and Waiver of Subrogation. Additional Insured wording to include: Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

*(Charter-party carriers of passengers:)

If applicable, Provider shall comply with the Public Utilities Commission (PUC) General Order No. 115-G, which requires higher levels of insurance for charter-party carriers of passengers and is based on seating capacity as follows:

$1,500,000 if seating capacity is 8-15

$5,000,000 if seating capacity is over 15 unless otherwise amended by future regulations.

In the case of a charter-party carrier with seating capacity of 7 or less, CalOptima will require $1,000,000 Combined Single Limit.

5.2.3 Workers' Compensation:

Provider, at its sole cost and expense shall maintain a Workers' Compensation Insurance policy as required by the State of California with minimum limits as follows:

Employers' Liability Insurance:

$1,000,000 Bodily injury each accident

$1,000,000 Bodily injury policy limit

$1,000,000 Bodily injury each employee

Waiver of Subrogation wording is required and to include:

Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

5.2.4 Commercial Crime:

If applicable, Provider, at its sole cost and expense shall maintain a commercial crime policy covering theft and dishonesty, forgery and alterations, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property as follows:

Commercial Crime Insurance: $1,000,000 per occurrence

5.2.5 Cyber and Privacy Liability Insurance:

If applicable, Provider shall maintain the following minimum coverages for such length of time as necessary to cover any and all claims:

Cyber and Privacy Liability Insurance: $1,000,000 each coverage

(including Privacy and Network Liability;

Internet Media Liability;

Business Interruption and Expense;

Data Extortion;

Regulatory Proceeding; and

Data Breach Notification & Credit Monitoring)

5.2.6 Bonding:

If providing services which require bonding, Provider shall be bonded at amounts usual or customary in Provider's industry and type of service.

5.3 Insurer Ratings.

Such insurance shall be provided by an insurer:

(a) Rated by A.M. Best with rating of A- VII or better; and

(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.4 Captive Risk Retention Group/Self Insured:

Where any of the insurances mentioned by Section 5.2 above are provided by a Captive Risk Retention Group or self-insured, Section 5.3 above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

5.5 Cancellation or Material Change:

The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract. Thirty (30) days prior written notice be given to CalOptima in the event of cancellation.

5.6 Certificates of Insurance:

Certificates of Insurance of the above insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

5.7 Subcontractors:

Provider shall require each of its Subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

5.8 Failure or refusal to maintain or produce proof of Insurance:

If Provider fails or refuses to maintain or produce proof of the insurance required by Section 5.2, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect Provider's right to be paid for its time and materials expended prior to notification of termination. Provider waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of Insurance by CalOptima.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, CDA or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, CDA or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.3 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.4. Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.4.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.4.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.4.3 Declaration of Confidentiality. If Provider and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Provider and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.5 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The initial term of this Contract shall be for a period of two (2) years from the Effective Date. This Contract may be extended for three (3) consecutive one-year terms upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, permits and certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment,

CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits, as well as Provider's response to the CalOptima's Request for Proposal (RFP), if applicable, and any further information or clarification submitted as part of the RFP process, and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder. In the event of any inconsistency between the RFP and this Contract, the terms and provisions of this Contract shall govern and control.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

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

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Provider hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:

Cathleen Anthony
Name

Owner Kenady LLC DBA Lifespring Homenutrition
Title

872 W. 16th Newport Beach, CA 92663
Address

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

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

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Provider	**CalOptima**
Signature	Signature
Kathleen Anthony	Ladan Khamseh
Print Name	Print Name
Owner/Managing member	Chief Operating Officer
Title	Title
5/26/20	5/29/2020
Date	Date

ATTACHMENT A

CONTRACTED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Program. Provider shall furnish Covered Services to eligible Members in the following CalOptima Programs:

_____ Medi-Cal Programs

_____ Medicare Advantage Program (OneCare)

__X__ PACE Program

_____ Cal MediConnect Program/OneCare Connect (Members Dually Eligible for Medicare and Medi-Cal)

_____ Multipurpose Senior Services Program (MSSP)

ARTICLE 2
SERVICES

2.1 Scope of Work. "Covered Services" as referred to in this Contract means those items and services as defined under applicable CalOptima Programs and CalOptima Policies and required to be furnished under this Contract, and provided to Members who are authorized to receive such items and services including:

Congregate Meals

Defined as meals delivered to the PACE center prepared in accordance with the scope of services below, with an emphasis on meals that align with the cultural preferences of CalOptima PACE Participants and are provided with appropriate condiments to enhance the meal experience.

Home Delivered Meals

Defined as meals prepared and delivered to the home residences of PACE Participants or to the PACE center for holding prior to distribution at a later time by CalOptima PACE.

A. General Requirements of Services:

1. The purchase of Congregate Meals and Home Delivered Meal Services (Services) may be ordered in any quantities. There shall be no minimum order requirements and CalOptima shall be under no obligation to purchase any of the Services.
2. Prepare and deliver full lunch meals in sufficient quantity and quality within the time frame agreed to with the PACE Center. Meals delivered to PACE Center shall be prepared in a manner that can be adequately re-heated and served by PACE staff (if necessary). Meals must be prepared and provided by appropriately trained and certified food service staff in a manner that meets the requirements for Participants.
3. Maintain appropriate and current state and/or local certification demonstrating adequate food preparation facilities and transportation resources.
4. Maintain staff with training and experience able to provide safe, nourishing, palatable, and well-balanced meals that meet national standards for the elderly population being served. Upon PACE program request, provide the training and/or testing requirements and certifications of staff.
5. Provide on an ad-hoc basis to the PACE program specially catered meals at the PACE Center and/or meetings at pre-designated locations. PACE program will provide a minimum advance notice of no less than five (5) business days.
6. Cooperate in any member satisfaction survey which PACE program may choose to undertake.

B. Food Preparations:

1. Prepare meals in a facility that meets applicable state and local fire, health, sanitation, and safety regulations. Upon request, Contractor shall provide documentation to

PACE program of compliance with these regulations. Meals will be prepared under properly controlled temperatures and preparation shall not be completed more than four (4) hours prior to the scheduled delivery time.

2. Have facilities capable of preparing three (3) meals a day for delivery. This would include breakfast, lunch and dinner for those PACE participants confined to their homes.
3. Have ability to package the meals in safe and easy to use packaging with clear instructions for reheating on package label.
4. Maintain and provide the following records upon request:
   i. Food Temperature Log – one for congregate meals and one for home delivered meals.
   ii. Cleaning Schedule (s) for all vendor equipment
   iii. Equipment Temperature Log – for all dish machines, refrigerators, and freezers.
   iv. Water Temperature log
5. Adequate and suitable space (free from vermin, dirt, and contamination or adulteration) shall be provided for the storage of food and beverages, preparation, serving and eating utensils.
6. Food preparations shall be under the supervision of trained staff in food service management to ensure food service sanitation and the practices of hygienic food handling techniques are followed.
7. All meals shall be packaged and transported in a way it is protected from potential contamination and maintains appropriate hot and cold food temperatures.
8. Meal delivery vehicles and meal delivery equipment shall be maintained to meet sanitary food standards for the delivery of food.

C. Menus:

1. Contractor shall implement a process to work with the CalOptima PACE Supervisor of Dietary Services to provide appropriate meals for members in the PACE Center and at home in accordance with their plans of care. Menus shall be developed between the Contractor and the CalOptima PACE Registered Dietitian and approved by the PACE program.
2. Menus shall be developed monthly based on feedback and satisfaction surveys, with consideration for the health, cultural, ethnic, and regional dietary practices of Participants.
3. Multi-culturally appropriate meals shall be included at least once weekly and as requested for special functions (Hispanic, Vietnamese, Filipino, Chinese, Mediterranean, Middle Eastern, etc.). Menus shall also include traditional meals that are reflective of major holidays.
4. Special condiments, such as guacamole, sour cream, salsa, additional sauce/sides, dressings, condiment packets, meal garnish, or other meal enhancements as appropriate to the meal of the day, shall be included for enhanced aesthetic appeal and taste of meal.

D. Delivery:

1. Transportation of meals shall be completed in safe, easy-to-use packaging for serving or reheating to the proper temperature while still maintaining the meals' nutritive value, flavor, and appearance.
2. Pack food in insulated carriers, to maintain proper food temperatures during transportation.
   a. <u>PACE Center Delivery</u>
      i. Prepare and deliver full lunch meals in required quantity and quality within the time frame agreed to with the PACE program.
      ii. Deliver meals to PACE Center in accordance with PACE Center regular business hours between 8:00 a.m. - 9:00 a.m., up to three (3) times weekly or as required by the PACE program.
      iii. Follow the holiday schedule established by PACE program.
   b. <u>Home Delivery</u>

i. Deliver home meals to members in accordance with and as requested by the PACE program.

ii. Have the ability to deliver single meals designed to meet individual needs to members at home (if necessary), as indicated, for Monday through Friday during regular business hours, and occasionally after-hours or on the weekend for special circumstances (e.g., hospital discharge on weekend with special nutrition requirements), as instructed by the PACE Registered Dietitian (R.D) or other representative of interdisciplinary team (IDT).

iii. Agree to accept daily changes in the designated participants to be delivered meals at home.

E. Monthly Invoices:

1. Request for payment shall be through submission of a monthly detailed invoice, separating meals delivered to the PACE Center and those for home delivery. Invoice shall include:
   i. Member name
   ii. Date of delivery
   iii. Time of delivery
   iv. Type of delivery (PACE or home)
   v. Contract/Purchase Order Number

F. Performance Measures:

1. Performance and progress monitoring will be performed quarterly and conducted by the CalOptima PACE Program leadership.
2. Performance measures or outcome measures include:
   i. Maintain environmental health inspections in good standing.
   ii. Maintain the Annual Department of Health Award of Excellence.
   iii. Monthly menus submitted no less than one week prior to next month.
   iv. Ensure monthly approval of menu by Contractor's dietitian or nutritionist and PACE Registered Dietitian prior to finalizing menus.
   v. Ensure one to three new menu items quarterly.
   vi. Deliver meals at the scheduled time (+/- 15 minutes of the stated time.)
   vii. Maintain 90% adherence to stated menu (minimizing last minute changes.)
   viii. Submit updated reports, documents, and awards of excellence from county health department after inspections/reviews within 24 hours of inspections.

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICE

1. CALOPTIMA DIRECT MEMBERS AND PACE PARTICIPANTS

1.1 Cal Optima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) and PACE 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 and PACE Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;
b. Name and phone number of the care taker, if applicable;
c. Language or sign language needed;
d. Date and time of the appointment;
e. Address and telephone number of the facility where the appointment is to take place;
f. Estimated amount of time the interpretation service will be needed; and
g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request, and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

2. HEALTH NETWORK MEMBERS

2.1 Health Network Contact. Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT C
COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Medi-Cal Program Reimbursement

Not Applicable to this Contract

II. Medicare Advantage (OneCare) Program Reimbursement

Not Applicable to this Contract

III. PACE Program Reimbursement

For PACE Members, CalOptima shall reimburse for Covered Services as follows:

Year 1 Term Rate	Year 2 Term Rate	Rate as of Year 3 Term	Description
$5.75	$5.75	$5.75	Per congregate meal delivered to PACE Center
$6.80	$7.00	$7.00	Per individual meal delivered to the home or PACE Center
$10.00	$10.00	$10.00	Delivery charge per delivery to the PACE Center
$10.00	$10.00	$10.00	Delivery charge per each home delivery

Provider shall be capable of providing a monthly detailed invoice for those meals delivered to the PACE Center and a detailed invoice/claims with the Member name, identification number, and dates/times of delivery for those meals delivered at home. Meals must be delivered within 15 minutes of specified time for delivery charge to apply.

Provider shall submit to CalOptima an accurate, complete, descriptive, and timely invoice that includes, but is not limited to, Member Name, Member identification number, description of services, and date(s) of service. An invoice may not be submitted before the delivery of service. Provider agrees to submit invoice to CalOptima within ninety (90) days after the service is rendered. CalOptima reserves the right to deny payment for services that are not invoiced within the ninety (90) days of the date of service. Provider agrees to submit invoice to CalOptima, Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868.

IV. Cal MediConnect (OneCare Connect) Program Reimbursement

Not Applicable to this Contract

V. MSSP Program Reimbursement

Not Applicable to this Contract

ATTACHMENT D

DISCLOSURE FORM

Name of Provider

The undersigned hereby certifies that the following information regarding Lifespring Homecare (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):
Cathleen Anthony owner + managing member

Co-Owner(s):
—

Stockholder(s) owning more than five percent (5%) of the Provider's stock:
~

Major creditor(s) holding more than five percent (5%) of the Provider's debt:
—

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):
Limited Liability Corporation

Dated: 5/26/20

Signature: Cathleen

Name: Cathleen Anthony
(Please type or print)

Title: Owner - Managing member
(Please type or print)

ATTACHMENT 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.

Lifespring Homeworks / Kenady	Cathleen Anthony
Name of Contractor	Printed Name of Person Signing for Contractor
	[signature]
Contract / Grant Number	Signature of Person Signing for Contractor
5/26/20	Owner
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned	13. Type of Payment (Check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:
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 $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D

ADDENDUM 1
MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medi-Cal Program (COD and Health Network Members): These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. Provider shall maintain and retain all records of all items and services provided Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract for provision of services to CalOptima Medi-Cal Members due to fraud.

3. Form of Records. Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation.

5.1 Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or Subcontracts entered into under this Contract. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its subcontractor's possession, in accordance with the DHCS Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

5.2 In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2 If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.3 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. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

6. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

8. Medi-Cal Credentialing. If Provider is of a provider type that is not able to enroll in Medi-Cal through DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

9. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the

proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

10. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

10.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

10.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

10.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

10.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

11. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

11.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

11.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

11.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

11.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 12.1.2 herein; and

11.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

11.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

11.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

11.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

11.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

11.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

12. DHCS Directions. If required by DHCS, Provider shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Lobbying Restrictions and Disclosure Certification.

13.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

13.2 Certification and Disclosure Requirements

13.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 13.3 of this provision.

13.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 13.3 of this provision if paid for with appropriated funds.

13.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 13.2.2 herein. An event that materially affects the accuracy of the information reported includes:

13.2.3.1 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;

13.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

13.2.3.3 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.

13.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 13.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

13.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 13.2.1 of this provision.

That person shall forward all disclosure forms to DHCS program contract manager.

13.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. Additional Subcontracting Requirements.

14.1 Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

14.1.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

14.1.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later.

14.2 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

14.2.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

14.2.2 Subcontract or its amendments are subject to DHCS approval as provided in the DHCS Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract.

14.2.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 20 of this Addendum 1.

14.2.4 An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.21 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Addendum 1.

14.2.5 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 15 of this Addendum 1.

14.2.6 An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 14.1 of this Addendum 1.

14.2.7 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 15 of this Addendum 1.

14.2.8 An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the DHCS Contract or the Contract for any reason, in accordance with Section 18 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

14.2.9 An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.5 of the Contract.

14.2.10 An agreement to notify DHCS in the manner provided in Section 7.8 of the Contract in the event the Subcontract is amended or terminated.

14.2.11 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.15 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.14 or the Contract.

14.2.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract.

14.2.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.11 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

14.2.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 24 of this Addendum 1 and Section 6.4.3 of the Contract.

14.2.15 An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.5 of the Contract.

14.2.16 An agreement for the establishment and maintenance of and access to administrative records as set forth in Section 6.2 of the Contract and Sections 1 and 3 of this Addendum 1.

14.2.17 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

14.2.18 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.4.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

15. State's Right to Monitor. Provider shall comply with all monitoring provisions of this Contract and the DHCS Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS. Without limiting the foregoing, CalOptima and authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. The monitoring activities will be either announced or announced. Staff designated by authorized State agencies will have access to all security areas and the Provider will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

16. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

17. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or

requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

18. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's DHCS Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor DHCS Contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

19. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

20. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Provider or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

21. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation Provision".

22. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

23. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

24. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Provider agrees to retain books, records, Member medical, Subcontractor and other records for at least ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Provider and its Subcontractors agree to maintain and make available contracts, books, documents, and records involving transactions related to the Contract to CalOptima, DMHC, DHHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

3. Accountability Acknowledgement. Provider further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Provider pursuant to the Contract are consistent and comply with CalOptima's contractual obligations with CMS and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Provider under this Contract, Provider warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Provider agrees to perform the delegated activities in a manner consistent with the delegation criteria. Provider agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Provider acknowledges that delegation to another entity does not alter Provider's ultimate obligations and responsibilities set forth in this Contract. Provider acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

   (b) Reports on Delegated Activities. Provider agrees to provide CalOptima with periodic reports on delegated activities performed by Provider as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Provider agrees to take those corrective actions identified by CalOptima through the audit review process.

   (c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Provider, which will be monitored by CalOptima on an ongoing basis. In the event Provider breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Provider as set

forth in this Contract. Moreover, CalOptima shall have the right to require Provider to terminate any Subcontracting provider for good cause, including but not limited to breach of its obligations to perform any delegated duties.

4. Reporting Requirements. Provider shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting encounter and other data including, without limitation, 42 CFR § 422.516. Provider also agrees to furnish medical records that may be required to obtain any additional information or corroborate the Encounter Data.

ADDENDUM 3
PACE PROGRAM REQUIREMENTS

The terms and requirements of this Addendum 3 shall apply for services provided by Provider to Members who are enrolled in the CalOptima PACE program only.

1. State Approval and Termination.

   1.1. This Addendum to the Contract shall not become effective until approved in writing by the California Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services, (CMS), or by operation of law where DHCS and CMS have acknowledged receipt, verbally or in writing, and has failed to approve or disapprove the proposed contract within sixty (60) days of receipt.

   1.2. Amendments to this Contract and amendments to any subcontract agreements between Provider and Subcontractor shall be submitted to DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by DHCS shall become effective by operation of law within thirty (30) days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later.

   1.3. CalOptima may terminate this Contract as it applies to providing services to CalOptima PACE participants if CalOptima's PACE Agreement or State Medi-Cal contract is terminated for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or State Medi-Cal contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS/CMS, or the State Medi-Cal Contract from DHCS.

2. Provider's Responsibilities applicable to providing services to CalOptima PACE enrollees. Provider shall be accountable to CalOptima in accordance with the terms of this Contract. For CalOptima PACE enrollees, Provider agrees to do the following:

   2.1. Provider shall make available a location that is accessible to PACE participants within the PACE service area of Orange County, California.

   2.2. Duties Related to Provider's Position. Provider shall perform all the duties related to its position, as specified in this Contract.

   2.3. Services Authorized. Provider shall furnish only those services authorized by the CalOptima PACE Interdisciplinary Team (IDT); PCP referral is deemed as an IDT authorization.

   2.4. Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Provider shall participate in CalOptima PACE Interdisciplinary Team meetings as required. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

   2.5. Payment in Full. Provider shall accept CalOptima's payment as payment in full, and shall not seek any reimbursement for services directly from the CalOptima PACE member, Medi-Cal, Medicare or other insurance carrier or provider. Provider shall not seek any type of copayment from PACE member for Covered Services. CalOptima PACE participants shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against CalOptima PACE participants to collect sums that are owed by CalOptima. Surcharges to CalOptima PACE participants by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Contractor shall reimburse the participant as appropriate.

   2.6. Hold Harmless. In accordance with the Medi-Cal Contract and the PACE Agreement, Provider will not bill the State of California, CMS or CalOptima PACE participants in the event CalOptima cannot or will not pay for services performed by Provider pursuant to this Contract.

   2.7. Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and DHHS, as may be necessary for compliance by CalOptima with its statutory

obligations, and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

2.8. Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under this Contract, such physician/provider shall (a) accept Provider's fees from CalOptima as full payment for services delivered to CalOptima PACE participants, (b) bill services provided through Provider's office, unless Provider has made other billing arrangements with CalOptima, (c) not bill CalOptima PACE participants directly, under any circumstances, and (d) cooperate with and participate in CalOptima's quality assurance and improvement program.

2.9. Participant Bill of Rights. Provider shall cooperate and comply with the CalOptima PACE Participant Bill of Rights. A copy of the CalOptima PACE Participant Bill of Rights is attached. CalOptima may, at its sole discretion, make reasonable changes to this document from time to time, and a copy of the revised document will be sent to Provider.

2.10 The CalOptima PACE program director or his or her designee shall be designated as the liaison to coordinate activities between Provider and PACE.

3. Records Retention. Provider and its Subcontractors shall maintain and retain all records, including Encounter Data, of all items and services provided Members for ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, which ever is later, unless a longer period is required by law. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

4. Access to Books and Records. Provider and its Subcontractors agree to make all of its books and records pertaining to the goods and services furnished under, or in any way pertaining to, the terms of Contract and any Subcontract, available for inspection, examination and copying by the Government Agencies, including the DOJ, CDA, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, at all reasonable times at the Provider's or Subcontractor's place of business or such other mutually agreeable location in California, in a form maintained in accordance with general standards applicable to such book or record keeping. Provider shall provide access to all security areas and shall provide and require Subcontractors to provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties.

Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.

This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

6. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima. For purposes of this Section and this Contract, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity; and/or (iv) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

7. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

8. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

9. DHCS Policies. Covered Services provided under this Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division (LTCD).

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number,

symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

11.1 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

11.1.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

11.1.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

11.1.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

11.1.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

12. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions, unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14. Provider shall have a right to submit an Appeal through the mechanisms set forth in CalOptima Policies regarding Provider dispute resolution.

ADDENDUM 4
CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Cal MediConnect Program. These terms and conditions are additive to those contained in the main Contract. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Provider shall provide services or perform other activity pursuant to this Contract in accordance with (i) applicable DHCS and CMS laws, regulations, instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS.
2. Provider shall (i) safeguard Member privacy and confidentiality of Member health records (ii) comply with all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.
3. The performance of the Provider and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Provider shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.
4. Provider shall also allow CalOptima to use performance data for purposes including, but not limited to, quality improvement activities, monitoring, and, public reporting to consumers as identified in CalOptima policy.
5. Provider shall submit timely and accurate encounter data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
6. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall, in its policies, administration, and services, practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through cultural diversity training, fostering in staff and Subcontractors attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall provide translation of written materials in the Threshold Languages and Concentration Languages identified by CalOptima at no higher than the sixth (6th) grade reading level.
7. Provider shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.
8. Provider shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of Provider. Provider may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member; or communicate with respect to the method by which such Provider is compensated by the Contractor for services provided to the Member. CalOptima will not refuse to contract or pay Provider for the provision of covered services under the CalOptima Cal MediConnect Program solely because Provider has in good faith communicated or advocated on behalf of a Member as set forth above.
9. CMS Participation Requirements. Provider represents and warrants that: (i) neither Provider nor any of its employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("Federal Health Care Program(s)"); (ii) Provider has not arranged or contracted with (by employment or otherwise) with any employee, contractor or agent that Provider knows or should know are excluded from participation in Federal Health Care Programs; (iii) no action is pending against Provider or any of its employees or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Provider agrees to immediately notify CalOptima in the event that it learns that it is or has employed or contacted with a person or entity that is excluded from participation in any Federal Health Care Program. In the event Provider fails to comply with the above,

CalOptima reserves the right to require Provider to pay immediately to CalOptima, the amount of any sanctions or other penalties that may be imposed on CalOptima by DHCS and/or CMS for violation of this prohibition, and Provider shall be responsible for any resulting overpayments.

10. Downstream Entity Contracts.

10.1 If any services under this Contract are to be provided by a Downstream Entity on behalf of Provider, Provider shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414. Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including but not limited to, the following:

10.1.1 An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 4 and Section 2.18 of the Contract.

10.1.2 An agreement to (i) Member financial protections in accordance with Section 4.5 of the Contract, including prohibiting Downstream Entities from holding an Member liable for payment of any fees that are the obligation of the Provider, and (ii) safeguard Member privacy and confidentiality of Member health records.

10.1.3 An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 11 of this Addendum 4 and the reporting requirements of Section 5 of this Addendum 4.

10.1.4 An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 12 of this Addendum 4 and 2.13 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 4.

10.1.5 If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 13 of this Addendum 4.

10.1.6 An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 14 of this Addendum 4.

10.1.7 Language that specifies the First Tier, Downstream and Related Entities must comply with the federal and state laws, regulations and CMS instructions.

10.1.8 Notify DHCS in the even the agreement with the subcontract is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

10.2 In addition to Section 10.1 of this Addendum 4, Provider shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

10.2.1 Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Provider.

10.2.2 An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

10.2.3 An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, in accordance with Section 6 of this Addendum 4.

10.2.4 An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 4.

10.2.5 An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 4.5.1 of the Contract and Section 19 of this Addendum.

10.2.6 An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 8 of this Addendum 4, and (ii) specified

circumstances where indemnification is not required by provider as set forth in Section 16 of this Addendum 4.

10.2.7 An agreement that the medical provider assist the Provider and/or CalOptima in the transfer of care of a Member in accordance with Section 15 of this Addendum.

10.2.8 An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 4, and (ii) to notify DHCS in the manner set forth in Section 7.8 of the Contract in the event the subcontract is amended or terminated.

10.2.9 An agreement to (i) gather, preserve, and provide records as set forth in Section 18 of Addendum 4, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under the Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Provider and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

10.2.10 An agreement to (i) participate and cooperate in quality improvement system as set forth in Section 2.11 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites in accordance with Section 2.15 of the Contract.

11. Right of Inspection, Evaluation, and Audit of Records. Provider and its Downstream Entities agree to maintain and make available contracts, books, documents, records, computer, other electronic systems, medical records, and any pertinent information related to the Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory or accrediting organizations or their designees to inspect, evaluate, and audit for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to above, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Provider's provision of health care services to Members, the cost of such services, and payments received by Provider from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

12. Provider and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 2.13 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Provider and/or its Downstream Entities have not performed satisfactorily.

13. Review of Credentials. Provider shall ensure that the credentials of medical professionals affiliated with the Provider are reviewed by it. Provider agrees that CalOptima will review, approve, and audit Provider's credentialing process on ongoing basis.

14. Provider Terminations. In the event a provider is terminated for cause by Professional, Provider shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Provider terminates a provider for deficiencies in the quality of care provided, Provider shall give notice of the action to the appropriate licensing and disciplinary agencies.

15. Provider agrees to assist CalOptima in the transfer of care of a Member. Provider shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

16. Provider is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

17. Assignment or Delegation. Provider agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from

DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Provider or Downstream Entity; (iii) the merger, reorganization, or consolidation of Provider or Downstream Entity, with another entity with respect to which Provider or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Provider or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Provider or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Provider agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Provider's or its Subcontractor's possession.

19. In addition to Section 4.5.1 of the Contract, Provider acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

ADDENDUM 5
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

The terms and requirements of this Addendum 5 shall apply for services provided by Provider to Members who are enrolled in the CalOptima Multipurpose Senior Services Program.

1. MSSP Site Manual. is the Multipurpose Senior Services Program (MSSP) Site Manual, dated July 1, 1992, produced by the CDA, and all subsequent amendments and revisions. Provider shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA Medi-Cal Services Branch, including any subsequent changes to State and Federal Law.

2. Vendor Application Form. Provider shall complete a CDA-approved Vendor Application Form. Provider shall submit to CalOptima any changes to the information contained in the Vendor Application Form within 15 days of any change.

3. Training/Education. Provider agrees to provide ongoing education and training, at least annually, for all employees and Subcontractors who handle personal, sensitive or confidential information. Provider employees and Subcontractors will complete the Security Awareness Training module located on the Department of Aging's website, www.aging.ca.gov, within 30 days of the start date of this Contract, or within 30 days of the start date of any new employee or Subcontractor. Provider may substitute its own Security Training program for CDA's Security Awareness Training program, provided such training meets or exceeds CDA's training requirement. Provider shall maintain documentation of training and education provided to their staff and/or Subcontractors. All employees, volunteers and Subcontractors who handle personal, sensitive or confidential information relating to CDA's programs must participate in Security Awareness Training.

4. Provider Confidentiality Statement. The Provider shall sign and return a Contractor/Vendor Confidentiality Statement (CDA 1024 Form) with this Contract. This is to ensure that Contractor/Vendors are aware of, and agree to comply with, their obligations to protect CDA information assets from unauthorized access and disclosure.

5. Travel Reimbursement Limits. In the event that this Contract provides for the reimbursement of authorized travel, any reimbursement for such authorized travel shall be at a rate not to exceed those amounts paid by the State in accordance with the Department of Personnel Administration's rules and regulations, which may be found at http://www.dpa.ca.gov/textdocs/freepmls/PML2008019.pdf (generally), http://www.dpa.ca.gov/personnel-policies/travel/meals-and-incidentals.htm (per diem), and http://www.dpa.ca.gov/personnel-policies/travel/short-term-travel.htm (lodging). This is not to be construed as limiting Provider from paying any differences in costs, from funds not derived from MSSP, between the Department of Personnel Administration rates and any rates Provider is obligated to pay under other contractual agreements. No travel outside of the State of California shall be reimbursed, unless prior written authorization from the State is obtained (CCR, Title 2, Section 599.615 et seq.).

6. The Provider shall maintain complete records (which shall include, but not be limited to, accounting records, contracts, agreements, letters of agreement, insurance documentation in accordance with Article XII., Memoranda and/or Letters of Understanding, and patient records) of its activities and expenditures hereunder in a form satisfactory to CDA, and shall make all records pertaining to this Contract available for inspection and audit by CalOptima and the State, or either's duly authorized agents, at any time during normal business hours. All such records must be maintained and made available by the Provider; (a) until an audit has occurred and an audit resolution has been issued, or unless otherwise authorized in writing by CDA or DHCS' Audit Branch, (b) for such longer period, if any, as is required by applicable statue, by any other clause of this Contract, or (c) for such longer period as CDA deems necessary.

AMENDMENT 1 TO
ANCILLARY SERVICES CONTRACT
NON-MEDICAL PROVIDER

THIS AMENDMENT 1 TO THE ANCILLARY SERVICES CONTRACT NON-MEDICAL PROVIDER ("Amendment 1") is effective as of **March 1, 2022**, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and Kenady Corporation, dba **LifeSpring Nutrition** ("Provider"), with respect to the following facts:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract Non-Medical Provider ("Contract"), by which Provider has agreed to provide or arrange for the provision of Covered Services to Members.

B. In accordance with Article 7.1 of the Contract and as approved by the CalOptima Board of Directors, CalOptima and Provider shall exercise one (1) of the three (3) consecutive one-year term extensions at the end of the initial term of the Contract, which will end on May 31, 2022.

C. CalOptima and Provider desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Attachment C "Compensation" shall be deleted in its entirety and replaced with the new Attachment C – Amendment 1 "Compensation" attached herein.
2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment 2, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment 1.

FOR PROVIDER:	FOR CALOPTIMA:
Signature	Signature
Print Name	Yunkyung Kim Print Name
Title	Chief Operating Officer Title
Date	Date

DRAFT

ATTACHMENT C – AMENDMENT 1

COMPENSATION

Effective Date: March 1, 2022

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Medi-Cal Program Reimbursement
Not Applicable

II. Medicare Advantage (OneCare) Program Reimbursement
Not Applicable

III. PACE Program Reimbursement
For PACE Members, CalOptima shall reimburse for Covered Services as follows:

Reimbursement	Description
	Per congregate meal delivered to PACE Center
	Per individual meal delivered to the home or PACE Center
	Delivery charge per delivery to the PACE Center
	Delivery charge per each home delivery

Provider shall submit a monthly detailed invoice separating those meals delivered to the PACE Center and those meals for home delivery. The detailed invoice shall include the Member name, identification number, dates/times of delivery, type of delivery and the Purchase Order Number. Meals must be delivered within 15 minutes of specified time for delivery charge to apply.

Provider shall submit to CalOptima an accurate, complete, descriptive, and timely invoice that includes, but is not limited to, Member Name, Member identification number, description of services, and date(s) of service. An invoice may not be submitted before the delivery of service. Provider agrees to submit invoice to CalOptima within ninety (90) days after the service is rendered. CalOptima reserves the right to deny payment for services that are not invoiced within the ninety (90) days of the date of service. Provider agrees to submit invoice to CalOptima, Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868.

IV. Cal MediConnect (OneCare Connect) Program Reimbursement
Not Applicable

V. MSSP Program Reimbursement
Not Applicable

DRAFT

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
9. Approval of Modifications to CalOptima Customer Service Policies: DD.2001 and DD.2002

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

Recommended Action
Approve modifications to the following Customer Service policies and procedures:

1. Policy DD.2001 Member Rights and Responsibilities
2. Policy DD.2002 Cultural and Linguistic Services

Background/Discussion
CalOptima regularly reviews its Policies and Procedures to ensure they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations, and laws as well as CalOptima Operations.

Below is a description of the impacted policies, followed by a list of substantive changes to each policy, which are reflected in the attached redlines. The list does not include non-substantive changes that may also be reflected in the redlines (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

1. **Policy DD.2001 Member Rights and Responsibilities** outlines a member's rights and responsibilities and the process by which CalOptima communicates them to Members. This policy was revised to align with the 2022 DHCS Member Handbook.

Policy Section	Change
II.C	The 2022 DHCS Member Handbook uses simpler language to describe the member rights and responsibilities. CalOptima's policy was revised to use these simpler terms.

2. **Policy DD.2002 Cultural and Linguistic Services** describes CalOptima's efforts and requirements to provide culturally and linguistically appropriate services to members. This policy was revised to include updated requirements from:
   - All Plan Letter (APL) 20-015: State Non-Discrimination and Language Assistance Requirements;
   - APL 21-004: Standards for Determining Threshold Languages, Non-Discrimination Requirements, and Language Assistance Services; and
   - APL 21-011: Grievance and Appeal Requirements.

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Policy Section	Change
II.C, D, E	The policy change strengthens requirements related to compliance with federal and state non-discrimination laws including notifying members of these protections, monitoring grievances related to discrimination, and annual auditing of CalOptima and Health Networks for compliance.
III.G.1, G.1.b and G.1.g	The policy change adds guidelines for use of Video Remote Interpretation (VRI) services to provide interpreter services and access for members including technology and quality requirements.
III.G.1. j	The policy change expands the definition of reasonable accommodation for members with disabilities. Examples include, but are not limited to individualized assistance, note takers, written material, open and closed captioning, or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.
III.G.3	The policy change adds a requirement for CalOptima and Health Networks to inform members of their rights to file a grievance if a member fails to receive interpreter services.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations. CalOptima staff recommends that the Board of Directors approve and adopt the presented CalOptima policies and procedures. The updated policies and procedures will supersede prior versions.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Policy DD.2001: Member Rights and Responsibilities (Redlined and Clean)
2. Policy DD.2002: Cultural and Linguistic Services (Redlined and Clean)

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

Policy:	DD.2001
Title:	**Member Rights and Responsibilities**
Department:	Customer Service
Section:	Not Applicable
Interim CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220203 BOD Review Only

I. PURPOSE

This policy outlines a Member's rights and responsibilities and the process by which CalOptima communicates them to Members.

II. POLICY

A. CalOptima and its Health Networks shall inform a Member of his or her rights and responsibilities.

B. CalOptima and its Health Networks shall ensure that a Member's rights and responsibilities are respected and observed.

C. A Member shall have the right to:

~~1.~~ Be treated with respect and dignity ~~by all CalOptima, **Health Network**, and **Provider** staff;~~

~~2.~~1. ~~Privacy and~~, giving due consideration to ~~have~~ their right to privacy and the need to maintain confidentiality of medical information ~~kept confidential~~;

~~3.~~2. ~~Receive~~ Be provided with information about ~~CalOptima, contracted **Health Networks**, **Providers**,~~ the plan and its services, including Covered Services, practitioners, and Member rights and responsibilities;

~~4. Choose a **Primary Care Provider (PCP)** within the CalOptima network;~~

~~5.~~1. ~~Talk openly with health care providers~~Make recommendations about ~~**Medically Necessary** treatment options, regardless of cost, or benefit~~CalOptima's~~;~~

~~6. Ask for assistance to make health care decisions, including the right to say "no" to medical treatment;~~

~~7. Voice **Grievance**, or **Appeals**, either verbally, or in writing, about CalOptima or the care provided, including filing a request for an **Appeal** of an action within sixty (60) calendar days of the date on a **Notice of Action (NOA)**;~~

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8. Receive, at no cost, twenty-four (24) hour access to interpreter services at **Key Points of Contact**;

9. Receive, at no cost, translations of **Member** informational materials in **Threshold Languages**, oral translation for other languages upon request or as needed, and information and materials to meet the needs of sensory and hearing impairments;

10. Make an **Advance Directive**;

11. Access family planning services, **Federally Qualified Health Centers**, **Indian Health Service Facilities**, sexually transmitted disease services and emergency services outside the CalOptima network;

12. Ask for a State Hearing, including information on the conditions under which a **State Hearing** can be expedited;

13. Have access to his or her **Medical Record**, and where legally appropriate, receive copies of, update or correct the **Medical Record**;

14. Access **Minor Consent Services**;

15. Receive written **Member** information in Braille, large size print, and other formats upon request, at no cost, and in a timely manner appropriate for the format being requested;

16. Be free from any form of control, or limitation, used as a means of pressure, punishment, convenience, or revenge;

17. Receive information about his or her medical condition and treatment plan options in a way that is easy to understand;

18.3. Make suggestions to CalOptima about the Member rights and responsibilities; policy;

4. Be able to choose a Primary Care Provider (PCP) within CalOptima's network;

5. Have timely access to network Providers;

6. Participate in decision making regarding their own health care, including the right to refuse treatment;

7. Voice Grievances, either verbally or in writing, about the organization or the care received;

8. Get Care Coordination;

9. Ask for an Appeal of decisions to deny, defer or limit services or benefits;

10. Get no-cost interpreting services for their language;

11. Get free legal help through a local legal aid office or other groups;

12. Formulate Advance Directives;

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13. Ask for a State Hearing if a service or benefit is denied and have already filed an Appeal with CalOptima and are still not happy with the decision, or if the Member did not get a decision on the Appeal after thirty (30) days, including information on the circumstances under which an expedited hearing is available;

14. Access minor consent services;

15. Get no-cost written Member Information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code section 14182 (b)(12);

16. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

17. Be free from any form of discrimination, including, being excluded, or treated differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation;

18. Truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand, regardless of cost or coverage;

19. Have access to ~~Freely use~~and get a copy of Medical Records, and request that they be amended or corrected, as specified in Title 45 Code of Federal Regulations, sections 164.524 and 164.526, and in accordance with CalOptima Policies GG.1618: Member Request for Medical Records, and HH.3004Δ: Member Request to Amend Records;

~~19.~~20. Freedom to exercise these rights without ~~negatively~~adversely affecting how ~~he or she is~~Members are treated by CalOptima, Health Networks, Providers, or ~~the State; and~~DHCS;

21. Have access to Family Planning Services, Free Standing Birth Centers, Federally Qualified Health Centers, Indian Health Services Facilities, midwifery services, Rural Health Clinics, sexually transmitted infection services and emergency services outside CalOptima's network pursuant to the federal law; and

~~20.~~22. Ask for Continuity of Care (COC) with ~~providers~~Providers who are not in the CalOptima provider network in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

D. A Member shall have the responsibility to:

1. Know, understand, and follow the Member handbook;

2. Understand his or her medical needs, and working with health care Providers to create a treatment plan;

3. Follow treatment plans agreed to with health care Providers;

4. Tell CalOptima and health care Providers what they need to know about his or her medical condition to ensure care;

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5. Make and keep medical appointments, and inform the office when he or she must cancel an appointment;

6. Learn about medical conditions and how to stay healthy;

7. Take part in health care programs to stay healthy; and

8. Work with and be polite to health care Providers.

III. PROCEDURE

A. Informing a Member of his or her rights and responsibilities

1. CalOptima shall inform a Member of his or her rights and responsibilities, as described in this ~~policy~~Policy, and in CalOptima Policies GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance as follows:

   a. In the Member Handbook/Evidence of Coverage (EOC) available on the CalOptima website (www.caloptima.org) and provided to all Members upon ~~enrollment in the CalOptima program~~request, in accordance with CalOptima Policy DD.2005: Member ~~Handbook~~Informing Materials Requirements;

   b. On CalOptima's Website;

   c. Annually in the Member newsletter; and

   d. Upon a Member's request.

2. A ~~**Providers**~~Provider shall post a Member's rights and responsibilities, as described in this Policy, in the waiting room of the facility in which he or she renders services to Members.

B. A Member may file a ~~complaint,~~Grievance, including a Grievance alleging discrimination in accordance with CalOptima Policies DD.2013: Customer Service Grievance Process, HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance, HH.1104: Complaints of Discrimination, and HH.1103: ~~CalOptima~~ Health Network Member ~~Complaint~~Grievance and Appeal Process, if the Member believes that his or her rights, as described in Section II.C. of this Policy, have not been respected, or observed.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Member Handbook/Evidence of Coverage (EOC)
D. CalOptima Policy DD.2005: Member ~~Handbook~~Informing Materials Requirements
E. CalOptima Policy DD.2013: Customer Service Grievance Process
~~E.~~F. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services

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~~F.~~G. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
H. CalOptima Policy GG.1618: Member Request for Medical Records
~~G.~~I. CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance
~~H.~~J. CalOptima Policy HH.1103: ~~CalOptima~~ Health Network Member ~~Complaint~~ Grievance and Appeal Process
K. CalOptima Policy HH.1104: Complaints of Discrimination
~~I.~~L. CalOptima Policy ~~DD.2013: CalOptima Exempt Grievance Process~~ HH.3004Δ: Member Request to Amend Records
~~J.~~M. Department of Health Care Services (DHCS), All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (supersedes APL 15-019)
N. Welfare & Institutions Code Section 14182 (b)(12)
O. Title 42, Code of Federal Regulations (C.F.R.), §§164.524 and 164.526

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/28/2009	Department of Health Care Services (DHCS)	Approved as Submitted
10/12/2009	Department of Health Care Services (DHCS)	Approved as Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	11/01/1999	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2008	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	07/01/2009	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	03/01/2011	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2013	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	09/01/2014	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2016	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	06/01/2017	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	08/01/2018	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2019	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	TBD	DD.2001	Member Rights and Responsibilities	Medi-Cal

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IX. GLOSSARY

Term	Definition
Advance Directives	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a member is incapacitated.
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors ~~and as further described in CalOptima Policy HH.3009A: Access by member's Authorized Representative.~~.
Care Coordination	Services which are included in basic case management, complex case management, comprehensive medical case management services, person centered planning and discharge planning, and are included as part of a functioning medical home.
Continuity of Care	Services provided to a ~~member~~Member rendered by an out-of-network provider with whom the ~~member~~Member has pre-existing provider relationship.

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Term	Definition
Covered Services	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 6840, which~~ 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'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), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

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Term	Definition
~~Federally Qualified Health Center (FQHC)~~Family Planning Services	~~A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.~~Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Free Standing Birth Center	Defined by Title 42, United States Code, Section 1396d(I)(3)(B) as a health facility- 1. That is not a hospital; 2. Where childbirth is planned to occur away from a pregnant woman's residence; 3. That is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and 4. That complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider, CalOptima or Health Network employee, failure to respect a ~~member's~~Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima or Health Network to make an authorization decision.

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Term	Definition
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 to provide covered services to members assigned to that Health Network.
Indian Health Services Facility	Facilities operated with funds from the Indian Health Service (HIS) under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Key Points of Contact	Service sites for ~~members~~Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to ~~members~~Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or ~~member~~Member orientation meetings.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary ~~services~~ Covered Services to protect life, to prevent significant illness or significant disability, or ~~to~~ alleviate severe pain through the diagnosis or treatment of disease, illness, or injury~~.~~, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
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 program.
Member Information	Documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to, the Member Handbook/Evidence of Coverage; provider directory; welcome packets; marketing information; form letters, including Notice of Action letters and any notices related to Grievances, actions, and Appeals, including Grievance and Appeal acknowledgement and resolution letters; plan generated preventive health.

For 20220203 BOD Review Only

Term	Definition
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Minor Consent Services	Those covered services of a sensitive nature that a minor does not need parental consent to access, related to: 1. Sexual Assault, including rape; 2. Drug and alcohol abuse for a minor/child twelve (12) years of age or older; 3. Pregnancy; 4. Family planning; and 5. Sexually Transmitted Diseases (STDs) for a minor/child twelve (12) years of age or older.
Notice of Action (NOA)	~~The notification of an adverse benefit determination that is sent by Contractor to a member in accordance with the notice and timing requirements set forth in 42 CFR 438.404~~A formal letter from CalOptima informing a Member of an "Adverse Benefit Determination."
Primary Care Provider (PCP)	~~A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility~~A person responsible for supervising, coordinating, and providing initial and ~~primary care~~Primary Care to Members ~~and serves as; for initiating referrals; and, for maintaining~~ the ~~medical home for Members.~~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, ~~health maintenance organization,~~ or other person or institution that furnishes Covered Services.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the ~~Group~~Population Needs Assessment (~~GNA).~~PNA).

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Policy:	DD.2001
Title:	**Member Rights and Responsibilities**
Department:	Customer Service
Section:	Not Applicable
Interim CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220203 BOD Review Only

I. PURPOSE

This policy outlines a Member's rights and responsibilities and the process by which CalOptima communicates them to Members.

II. POLICY

A. CalOptima and its Health Networks shall inform a Member of his or her rights and responsibilities.

B. CalOptima and its Health Networks shall ensure that a Member's rights and responsibilities are respected and observed.

C. A Member shall have the right to:

1. Be treated with respect and dignity, giving due consideration to their right to privacy and the need to maintain confidentiality of medical information;

2. Be provided with information about the plan and its services, including Covered Services, practitioners, and Member rights and responsibilities;

3. Make recommendations about CalOptima's Member rights and responsibilities policy;

4. Be able to choose a Primary Care Provider (PCP) within CalOptima's network;

5. Have timely access to network Providers;

6. Participate in decision making regarding their own health care, including the right to refuse treatment;

7. Voice Grievances, either verbally or in writing, about the organization or the care received;

8. Get Care Coordination;

9. Ask for an Appeal of decisions to deny, defer or limit services or benefits;

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10. Get no-cost interpreting services for their language;

11. Get free legal help through a local legal aid office or other groups;

12. Formulate Advance Directives;

13. Ask for a State Hearing if a service or benefit is denied and have already filed an Appeal with CalOptima and are still not happy with the decision, or if the Member did not get a decision on the Appeal after thirty (30) days, including information on the circumstances under which an expedited hearing is available;

14. Access minor consent services;

15. Get no-cost written Member Information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code section 14182 (b)(12);

16. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

17. Be free from any form of discrimination, including, being excluded, or treated differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation;

18. Truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand, regardless of cost or coverage;

19. Have access to and get a copy of Medical Records, and request that they be amended or corrected, as specified in Title 45 Code of Federal Regulations, sections 164.524 and 164.526, and in accordance with CalOptima Policies GG.1618: Member Request for Medical Records, and HH.3004Δ: Member Request to Amend Records;

20. Freedom to exercise these rights without adversely affecting how Members are treated by CalOptima, Health Networks, Providers, or DHCS;

21. Have access to Family Planning Services, Free Standing Birth Centers, Federally Qualified Health Centers, Indian Health Services Facilities, midwifery services, Rural Health Clinics, sexually transmitted infection services and emergency services outside CalOptima's network pursuant to the federal law; and

22. Ask for Continuity of Care (COC) with Providers who are not in the CalOptima provider network in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services.

D. A Member shall have the responsibility to:

1. Know, understand, and follow the Member handbook;

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2. Understand his or her medical needs, and working with health care Providers to create a treatment plan;

3. Follow treatment plans agreed to with health care Providers;

4. Tell CalOptima and health care Providers what they need to know about his or her medical condition to ensure care;

5. Make and keep medical appointments, and inform the office when he or she must cancel an appointment;

6. Learn about medical conditions and how to stay healthy;

7. Take part in health care programs to stay healthy; and

8. Work with and be polite to health care Providers.

III. PROCEDURE

A. Informing a Member of his or her rights and responsibilities

1. CalOptima shall inform a Member of his or her rights and responsibilities, as described in this Policy, and in CalOptima Policies GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and HH.1102: Member Grievance as follows:

   a. In the Member Handbook/Evidence of Coverage (EOC) available on the CalOptima website (www.caloptima.org) and provided to all Members upon request, in accordance with CalOptima Policy DD.2005: Member Informing Materials Requirements;

   b. On CalOptima's Website;

   c. Annually in the Member newsletter; and

   d. Upon a Member's request.

2. A Provider shall post a Member's rights and responsibilities, as described in this Policy, in the waiting room of the facility in which he or she renders services to Members.

B. A Member may file a Grievance, including a Grievance alleging discrimination in accordance with CalOptima Policies DD.2013: Customer Service Grievance Process, HH.1102: Member Grievance, HH.1104: Complaints of Discrimination, and HH.1103: Health Network Member Grievance and Appeal Process, if the Member believes that his or her rights, as described in Section II.C. of this Policy, have not been respected, or observed.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Member Handbook/Evidence of Coverage (EOC)

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D. CalOptima Policy DD.2005: Member Informing Materials Requirements
E. CalOptima Policy DD.2013: Customer Service Grievance Process
F. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
G. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
H. CalOptima Policy GG.1618: Member Request for Medical Records
I. CalOptima Policy HH.1102: Member Grievance
J. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
K. CalOptima Policy HH.1104: Complaints of Discrimination
L. CalOptima Policy HH.3004Δ: Member Request to Amend Records
M. Department of Health Care Services (DHCS), All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (supersedes APL 15-019)
N. Welfare & Institutions Code Section 14182 (b)(12)
O. Title 42, Code of Federal Regulations (C.F.R.), §§164.524 and 164.526

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/28/2009	Department of Health Care Services (DHCS)	Approved as Submitted
10/12/2009	Department of Health Care Services (DHCS)	Approved as Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	11/01/1999	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2008	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	07/01/2009	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	03/01/2011	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2013	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	09/01/2014	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2016	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	06/01/2017	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	08/01/2018	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2019	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	TBD	DD.2001	Member Rights and Responsibilities	Medi-Cal

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IX. GLOSSARY

Term	Definition
Advance Directives	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a member is incapacitated.
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Care Coordination	Services which are included in basic case management, complex case management, comprehensive medical case management services, person centered planning and discharge planning, and are included as part of a functioning medical home.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Covered Services	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's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

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Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Free Standing Birth Center	Defined by Title 42, United States Code, Section 1396d(I)(3)(B) as a health facility- 1. That is not a hospital; 2. Where childbirth is planned to occur away from a pregnant woman's residence; 3. That is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and 4. That complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider, CalOptima or Health Network employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima or Health Network to make an authorization decision.
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 to provide covered services to members assigned to that Health Network.

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Term	Definition
Indian Health Services Facility	Facilities operated with funds from the Indian Health Service (HIS) under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Key Points of Contact	Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
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 program.
Member Information	Documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to, the Member Handbook/Evidence of Coverage; provider directory; welcome packets; marketing information; form letters, including Notice of Action letters and any notices related to Grievances, actions, and Appeals, including Grievance and Appeal acknowledgement and resolution letters; plan generated preventive health.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.

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Term	Definition
Minor Consent Services	Those covered services of a sensitive nature that a minor does not need parental consent to access, related to: 1. Sexual Assault, including rape; 2. Drug and alcohol abuse for a minor/child twelve (12) years of age or older; 3. Pregnancy; 4. Family planning; and 5. Sexually Transmitted Diseases (STDs) for a minor/child twelve (12) years of age or older.
Notice of Action (NOA)	A formal letter from CalOptima informing a Member of an "Adverse Benefit Determination."
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.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

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Policy:	DD.2002
Title:	**Cultural and Linguistic Services**
Department:	Customer Service
Section:	Not Applicable
Interim CEO Approval:	*/s/*
Effective Date:	10/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy ensures effective communication to Members regarding treatment, diagnosis, medical history, and health education by providing culturally, linguistically, and ~~sensory~~ appropriate services to all Members, taking into consideration Members' beliefs, traditions, customs, and individual differences.

II. POLICY

A. CalOptima and its Health Networks shall provide culturally and linguistically appropriate services to Members. Specifically, CalOptima and its Health Networks shall:

1. Recruit bilingual employees for appropriate positions whenever possible, and enhance employees' bilingual skills and cultural sensitivity through employee development programs, as needed;

2. Provide, at no cost to the Member, twenty-four (24) hour access to ~~interpreter~~Qualified Interpreter services at Key Points of Contact;

3. Provide, at no cost to the Member, translations of Member informational materials in Threshold Languages, oral translation for other languages upon request or as needed, by a qualified translator, and information and materials to meet the needs of Members with sensory and hearing impairments;

4. Adhere to Department of Health Care Services (DHCS) requirements for determining language threshold; and

5. Refer Members to culturally and linguistically appropriate community services, as needed.

B. CalOptima shall establish a Member Advisory Committee (MAC) comprised of community advocates and ~~members~~Members representing a cross-section of the CalOptima Member population, as defined by CalOptima Board Resolution Numbers 2-14-95 (effective ~~in~~ February 14, 1995), 11-1103 (effective ~~in~~ November 3, 2011), and 15-08-06-02 (effective July 1, 2015). The MAC shall meet the Community Advisory Committee requirements and shall be overseen by the

Executive Director of Operations. The MAC shall provide information and recommendations with respect to CalOptima's Cultural and Linguistic ~~(C&L)~~ Services and shall collaborate with the CalOptima Provider Advisory Committee (PAC) with regard to ~~C&L~~Cultural and Linguistic Services on an ad hoc basis.

C. CalOptima and its Health Networks shall comply with applicable Federal and State civil rights laws, including, but not limited to, Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, and do not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.

1. CalOptima and its Health Networks shall post notices of non-discrimination, in at least twelve (12)-point font, in accordance with requirements set forth by the DHCS.

2. CalOptima and its Health Networks shall include a notice of non-discrimination on written Member-informing materials, and in all informational notices targeted to Members, potential enrollees, and the public, in accordance with requirements set forth by the DHCS.

D. CalOptima shall monitor Member Grievances, report Grievances related to Cultural and Linguistic Services, and shall designate a discrimination grievance coordinator who is responsible for ensuring compliance with Federal and State nondiscrimination requirements for appropriate action, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

E. The Office of Compliance shall perform annual audits to ensure CalOptima and its Health Networks are in compliance with cultural and linguistic regulatory requirements and may impose Sanctions and/or a Corrective Action Plan (CAP), in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

III. PROCEDURE

A. On an annual basis, CalOptima shall identify health education and ~~C&L~~cultural and linguistic needs by conducting a Population Needs Assessment (PNA) to facilitate the development of programs and services. CalOptima shall:

1. Provide the MAC an opportunity to provide comment on the PNA;

2. Report PNA findings to the MAC;

3. Discuss improvement opportunities; and

4. Update the MAC on progress made to PNA goals.

B. PNA and Cultural and Linguistic Services Work Plan

1. CalOptima and its Health Networks shall develop a ~~C&L~~Cultural and Linguistic Services Work Plan and shall designate a professional, the ~~C&L Manager~~cultural and linguistic manager, who has expertise in ~~C&L~~Cultural and Linguistic Services to be responsible for planning, managing, and evaluating activities conducted under the ~~plan~~Work Plan and shall oversee ~~C&L~~cultural and linguistic staff as specified in Attachment A. The ~~C&L~~Cultural and Linguistic Services Work Plan shall be reviewed annually and updated as needed.

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C. CalOptima and its Health Networks shall assess, identify, and report the linguistic capabilities of interpreters, bilingual employees, and Contracted Providers by:

1. Providing verification that a multiple-step process is used in the recruitment and hiring process of interpreters and bilingual employees.

a. Such process shall include technical qualification testing, bilingual, interpreting, and/or translation proficiency testing and background check.

2. Testing and continually training interpreters, translators, bilingual employees, and Contracted Providers.

3. Annually, or upon request, providing training and certification verification of their interpreters, translators, bilingual employees, and Contracted Providers.

D. CalOptima and its Health Networks comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

1. CalOptima shall include a notice of non-discrimination on written member-informing materials, in accordance with requirements set forth by the DHCS.

E. CalOptima and its Health Networks shall provide language assistance services, free of charge, for Members who speak a language other than English.

1. CalOptima shall include language taglines, compliant with requirements set forth by the DHCS, on written member-informing materials.

1. CalOptima shall ensure equal access to health care service for its Members without regard to a Member's proficiency in the English language. CalOptima will provide interpreter services adequate to communicate the medical, social, and psychological issues of its Members when necessary.

E. CalOptima and its Health Networks shall ensure Members receive information in Threshold Languages regarding a Member's right to file a grievance. Grievance forms and procedures shall be readily available to Members in Threshold Languages, and in alternative formats, such as large print in at least eighteen (18) point size font, audio format, or Braille, upon request or as needed. Oral interpretation shall also be available to help the Member understand the information provided.

F. CalOptima shall monitor Member complaints and grievances, and report complaints and grievances related to C&L Services to the Quality Improvement Committee (QIC) for appropriate action.

G. The Office of Compliance shall perform annual audits to ensure CalOptima and its Health Networks are in compliance with C&L regulatory requirements and may impose Sanctions and a Corrective Action Plan (CAP), in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

III. PROCEDURE

A. PNA and C&L Services Plan

2. CalOptima shall assign a professional who is trained and has expertise in health education or community health to conduct the PNA. This professional shall be responsible for coordinating

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with CalOptima ~~C&L~~Cultural and Linguistic Services and Health Education Department staff to implement effective health education and ~~C&L~~cultural and linguistic programs resulting from the PNA, and for reporting on the PNA and related activities to the ~~QIC~~Quality Improvement Committee, as required.

3. CalOptima shall develop a ~~C&L~~Cultural and Linguistic Services Work Plan to provide appropriate services to meet the needs of Members. The ~~C&L~~Cultural and Linguistic Services Work Plan shall address the needs identified in the PNA and shall be submitted to DHCS, as required.

4. CalOptima's ~~C&L~~cultural and linguistic Manager shall annually present the ~~C&L Goals and Objectives~~cultural and linguistic goals and objectives to the MAC and PAC and shall request input on the implementation of ~~C&L initiatives as specified in Attachment A~~Cultural and Linguistic Services Work Plan.

~~B.~~C. Employee Recruitment and Development

1. CalOptima and its Health Networks shall make best efforts to recruit qualified culturally, sensitive and bilingual employees, especially for positions that require direct Member communication.

2. CalOptima and its Health Networks shall assess the language capability of an employee to determine the employee's proficiency level for an assignment that includes the use of bilingual skills.

3. CalOptima and its Health Networks shall enhance an employee's ability to communicate managed care and medical care terminology to Members in their preferred language through training and development programs.

4. CalOptima and its Health Networks shall provide comprehensive staff training to ensure a Member with a sensory impairment is assisted in accessing information, services, and benefits.

5. CalOptima and its Health Networks shall encourage employees to attend cultural sensitivity seminars and workshops offered by CalOptima, professional organizations, universities, or colleges in order to develop Cultural Competency, including, but not limited to:

   a. Developing attitudes that value and respect diversity;

   b. Enhancing knowledge and awareness of beliefs, behaviors, and preventive health practices;

   c. Acquiring skills to communicate with Members with diverse language needs, including sign language interpreter services; and

   d. Developing the ability to address the health needs of diverse populations.

D. CalOptima and its Health Networks shall assess, identify, and report the linguistic capabilities of Interpreters, bilingual employees, and Contracted Providers by:

1. Providing verification that a multiple-step process is used in the recruitment and hiring process of Interpreters and bilingual employees.

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a. Such process shall include technical qualification testing, bilingual, interpreting, and/or translation proficiency testing and background check.

2. Testing and continually training Interpreters, translators, bilingual employees, and Contracted Providers.

3. Annually, or upon request, providing training and certification verification of their Interpreters, translators, bilingual employees, and Contracted Providers.

E. CalOptima and its Health Networks shall provide language assistance services, free of charge, for Members who speak a language other than English and shall:

1. Include language taglines, compliant with requirements set forth by the DHCS, on Member-informing materials, such the Notice of Privacy Practices.

2. Include translation and oral interpretation and large print taglines no smaller than twenty (20)-point font, and explain how to request free language assistance services and auxiliary aids and services.

3. Ensure equal access to health care service for its Members and potential members without regard to a Member's proficiency in the English language. CalOptima will provide Interpreter services adequate to communicate the medical, social, and psychological issues of its Members, when necessary, in compliance with federal and state law, and DHCS All Plan Letter (APL) 20-015: State Non-Discrimination and Language Assistance Requirements.

F. CalOptima and its Health Networks shall ensure Members receive information in Threshold Languages regarding a Member's right to file a Grievance. Grievance forms and procedures shall be readily available to Members in Threshold Languages, and in alternative formats, such as large print in at least twenty (20) point size font, braille or audio format, upon request or as needed. Oral interpretation shall also be available to help the Member understand the information provided.

~~F.~~G. Interpreter Services and Access for Members with Sensory Impairments

1. CalOptima and its Health Networks shall provide Members with linguistic ~~interpreter~~Interpreter services, American Sign Language (ASL) ~~interpreter~~Interpreter services, and information about the ~~Telecommunications Device for the Deaf (TDD~~Teletypewriter (TTY) or California Relay Service (CRS) to Members with hearing or speech impairments~~.~~. CalOptima and its Health Networks shall provide primary consideration to the individual's request of a particular auxiliary ~~aids for~~ aid or service such as Members with visual, hearing and speech impairments, as necessary, to ensure effective communication regarding treatment, diagnosis, medical history, or health education. Interpretation can take place in-person, through a telephonic Interpreter, or via internet or video remote interpreting (VRI) services. VRI services, must provide real-time motion video and audio over a dedicated high-speed, wire-bandwidth video connection that delivers high-quality video images that do not produce lags, choppy, blurry or grainy images, or irregular pauses in communication; a sharply delineated image that is large enough to display the interpreter's face, arms, hand, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position; a clear, audible transmission of voices; and adequate training of users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

a. CalOptima and its Health Networks shall provide, at no cost to the Member, twenty-four (24)-hour access to ~~interpreter~~Interpreter services at Key Points of Contact.

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b. When providing interpretive services, CalOptima and its Health Networks shall use Qualified Interpreters to interpret for an individual with a disability, whether through a remote interpreting service or an on-site appearance.

~~b.~~c. CalOptima and its Health Networks shall educate Providers regarding the process to access ~~interpreter~~no-cost Interpreter services for Members.

~~c.~~d. CalOptima and its Health Networks shall provide notice of no cost ~~interpreter~~Interpreter services through the CalOptima Member Handbook and other communications, including, but not limited to posters and flyers distributed at sites where Members receive Covered Services, Member ~~Newsletters~~newsletters and at Member orientation sessions.

~~d. CalOptima and its Health Networks shall inform Members of their right to file a complaint if a Member fails to receive interpreter services, in accordance with CalOptima Policies HH.1102: CalOptima Member Complaint and HH.1103: CalOptima Health Network Member Complaint.~~

e. If a Member or Provider requests an ~~interpreter~~Interpreter in a situation where Covered Services are needed, CalOptima or the Member's Health Network shall provide an ~~interpreter~~Interpreter in time to adequately assist with all necessary care, including Urgent Care and Emergency Services.

f. When possible, and appropriate, CalOptima and its Health Networks shall make all reasonable efforts to ensure assignment of the same face-to-face ~~interpreter~~Interpreter to Members who require follow-up care.

g. CalOptima and its Health Networks shall utilize a vendor for telephone ~~interpreter~~Interpreter services for languages not spoken by bilingual employees, for Urgent Care and Emergency Services or as needed. CalOptima and its Health Networks are prohibited from using remote audio or VRI services that do not comply with federal quality standards, or relying on unqualified bilingual/multilingual staff, Interpreters, or translators.

h. CalOptima and its Health Networks may schedule Face-to-face ~~interpreter~~Interpreter services, including ASL ~~interpreter~~Interpreter services, ~~may be scheduled~~ through a contracted vendor.

i. CalOptima and its Health Networks shall utilize the ~~TDD~~TTY, the CRS, or a comparable device or service available to assist Members with a hearing or speech impairment.

j. CalOptima ~~and~~, its Health Networks, and Contracted Providers shall ensure that Members with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the ~~particular need of the Member and include but are not limited to individualized assistance~~need of the Member and include, but are not limited to, individualized assistance, note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other

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effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.

k. CalOptima and its Health Networks shall make informational or educational materials readily available to Members in Threshold Languages, and in alternative formats, such as large print in at least ~~eighteen (18~~twenty (20) point size font, braille or audio format~~, or Braille~~, upon request or as needed, at no cost to the Member, within twenty-one (21) calendar days upon receipt of request. CalOptima and its Health Networks shall inform Members of the availability of these materials through the Member Handbook/EOC booklet and other mechanisms, including, but not limited to, posters and flyers distributed at sites where Members receive Covered Services and at Member orientation sessions.

l. CalOptima ~~enables~~and its Health Network shall enable Members to make a standing request to receive all informing material in a specified alternative format.

m. CalOptima and its Health Networks and Providers shall document a Member's language needs in the Member's file. Documentation in the Member's file shall include the Member's request or refusal of ~~interpreter~~Interpreter services.

2. CalOptima and its Health Networks shall not require or suggest to a Member to use friends or family Members, particularly minors, as interpreters. A Member's friend or family Members may be used as interpreters if the following conditions are met:

a. The Member is advised that an ~~interpreter~~Interpreter is available at no cost to the Member;

b. It is requested by the Member;

c. It will not compromise the effectiveness of service; and

d. It will not violate the Member's confidentiality.

e. In an emergency only, a minor child may be used as an interpreter if requested by the Member.

3. CalOptima and its Health Networks shall inform Members of their right to file a complaint if a Member fails to receive Interpreter services, in accordance with CalOptima Policies HH.1102: Member Grievance and HH.1103: Health Network Member Grievance and Appeal Process.

H. Translation Services

1. CalOptima and its Health Networks shall provide, at no cost to the Member, translation of written informing documents in Threshold Languages~~.~~ and concentration languages identified by DHCS. Written informing documents provide essential information regarding access and usage of Covered Services, and include, but are not limited to:

a. Member Handbook/EOC booklet;

b. Member Consent forms;

c. Disclosure forms;

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d. Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a ~~grievance~~Grievance or ~~appeal~~Appeal;

e. Provider listings or directories;

f. Marketing materials;

g. Notices advising limited-English-proficient persons of the availability of free language assistance;

h. Form letters;

i. Preventive health reminders; and

j. Member surveys and newsletters.

2. CalOptima and its Health Networks shall provide, upon a Member's request, a ~~written translation~~Written Translation of a non-standardized Member-specific document into Threshold ~~language~~Language within twenty-one (21) calendar days.

3. To ensure the quality of the translation, CalOptima and its Health Networks shall select qualified translators when translating written content in paper or electronic form, have an editor for translated documents, and provide for legal review of legal documents~~, including~~. The process shall include having the translated documents translated back to English to ensure the accuracy of the translation.

4. To ensure non-English translations of documents meet the same standards as the English versions, translated documents shall conform to the same document standards as the English versions, which may include but is not limited to, reading level and font size.

5. CalOptima and its Health Networks shall provide translations of written informing documents at a reading level no higher than sixth (6th) grade, or that is appropriate, as determined by other processes such as Field-Testing or the PNA, to the extent that compliance with the requirement does not conflict with regulatory agency directives or other legal requirements.

I. Cultural Competency Training and Education

1. CalOptima and its Health Networks shall provide initial and continuing training to Contracted Providers on Cultural Competency issues. CalOptima and its Health Networks may:

a. Conduct the training in conjunction or collaboration with other Health Networks or with CalOptima; or

b. Work with community organizations or educational institutions to provide the training.

J. Referral to Culturally and Linguistically Appropriate Services

1. CalOptima and its Health Networks shall develop working relationships with community-based and faith-based organizations and shall refer a Member to culturally and linguistically appropriate community services, as needed.

K. Monitoring and Evaluation of C&L Services

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1. A Health Network shall provide culturally and linguistically appropriate services to all Members, pursuant to the CalOptima Contract for Health Care Services, as well as applicable state and federal regulations.

2. CalOptima shall delegate to a Health Network the responsibility for monitoring the language capability of Contracted Providers listed as speaking specific languages in the Provider Directory. At a minimum, a Health Network shall:

    a. Document whether it is the Provider or the office staff who has the language skill(s).

        i. This information must be updated at least annually.

    b. Develop procedures for assessing ~~interpreters'~~Interpreters' language proficiency.

3. CalOptima, in consultation with its Health Networks, shall establish ~~C&L Service~~cultural and linguistic service standards. Using the ~~C&L Services~~cultural and linguistic service standards, CalOptima shall monitor and evaluate a Health Network's provision of ~~C&L~~Cultural and Linguistic Services, in accordance with CalOptima Policy GG.1619: Delegation Oversight as follows:

    a. Review the Health Network's ~~C&L~~cultural and linguistic policies and procedures;

    b. Review the Health Network's translated written informing documents, such as Member Handbooks, denial letters, consent forms, newsletters, outreach flyers and brochures, complaints and ~~grievance~~Grievance forms, and health education materials;

    c. Review the Health Network's documentation of efforts to recruit and retain bilingual employees;

    d. Review the Health Network's testing and training requirements for employees who utilize bilingual skills to assist Members;

    e. Review the Health Network's process for monitoring the language capability of Contracted Providers listed as speaking specific languages in the Provider Directory;

    f. Review the Health Network's training curriculum, schedules, and sign-in sheets to assess the training effort;

    g. Review the Health Network's community resource list to evaluate Member referrals to culturally and linguistically appropriate services; and

    h. Identify and monitor complaints and ~~grievances~~Grievances related to C&L Services.

4. CalOptima shall monitor and evaluate Health Network's training and education of Providers and staff, regarding the process of accessing ~~interpreter~~Interpreter services for Members. The Health Networks shall:

    a. Provide initial and continuous training and education to Contracted Providers and staff on the process to access ~~interpreter~~Interpreter services for Members.

    b. Annually, or upon request, provide verification of initial and continuous training.

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c. CalOptima shall perform audit test calls to Health Networks to determine the process for accessing ~~interpreter~~Interpreter services for Members and verifying that the process is appropriate for meeting Member's needs.

5. The Office of Compliance shall record the results of its assessment and evaluation of a Health Network's provision of ~~C&L~~Cultural and Linguistic Services using an audit tool and shall communicate the results to the Compliance Committee and the Health Network for appropriate action.

IV. ATTACHMENT(S)

A. ~~A.~~ Cultural and Linguistic Services Qualifications and Structure
B. Notice of Non-Discrimination and Language Tagline (Medi-Cal)

V. REFERENCE(S)

A. CalOptima Board Resolution 15-08-06-02
B. CalOptima Board Resolution 11-11-03
C. CalOptima Board Resolution 2-14-95
D. CalOptima Contract for Health Care Services
E. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
F. Cultural and Linguistic Services Plan
G. CalOptima Member Handbook/Evidence of Coverage (EOC)
H. CalOptima Policy GG.1201Δ: Health Education Programs
I. CalOptima Policy GG.1619: Delegation Oversight
J. CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance
K. CalOptima Policy HH.1103: ~~CalOptima~~ Health Network Member ~~Complaint~~ Grievance and Appeal Process
L. CalOptima Policy HH.1104: Complaints of Discrimination
~~L.~~M. CalOptima Policy HH.2002Δ: Sanctions
~~M.~~N. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~N. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-011: Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act~~
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-011: Health Education and Cultural and Linguistic Population Needs Assessment
~~P. Medi-Cal Managed Care Division (MMCD) Policy Letter 99-03: Linguistic Services~~
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-015: State Non-Discrimination and Language Assistance Requirements
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (supersedes APL 17-011 and Policy Letters 99-003 and 99-004)
~~Q.~~R. National Committee for Quality Assurance Standard – Element A: QI Program Structure, Factor 8 Objectives for serving a culturally and linguistically diverse membership
~~R.~~S. Title 42, Code of Federal Regulations (CFR), §438.10(d)
~~S.~~T. Title 45, Code of Federal Regulations (CFR), §84.52
U. Title 22, Code of California Regulations, §§53876 and 53895

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/01/2015	Department of Health Care Services (DHCS)	Approved as Submitted

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02/29/2016	Department of Health Care Services (DHCS)	Approved as Submitted
09/10/2020	Department of Health Care Services (DHCS)	Approved as Submitted
12/13/2021	Department of Health Care Services (DHCS)	Approved as Submitted

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	10/01/1998	DD.1107	Cultural and Linguistic Services	Medi-Cal
Revised	03/01/2000	DD.1107	Cultural and Linguistic Services	Medi-Cal
Revised	07/01/2000	DD.1107	Cultural and Linguistic Services	Medi-Cal
Revised	09/01/2004	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	08/01/2008	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	10/01/2011	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	01/01/2013	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	01/01/2014	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	12/01/2014	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	12/01/2015	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	08/01/2016	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	07/01/2017	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	12/01/2017	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	01/01/2019	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	02/01/2020	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	TBD	DD.2002	Cultural and Linguistic Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Contracted Provider	A ~~provider~~Provider who is obligated by written contract to provide ~~covered services~~Covered Services to ~~members~~Members on behalf of CalOptima, its contracted Health Networks or Physician Medical Groups.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. First tier, downstream and related entities, and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

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Term	Definition
Covered Services	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 ~~effective July 1, 2019,~~ to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Board of Directors, ~~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), effective January 1, 2020) for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors,~~ which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Cultural and Linguistic Services	Services that promote equal access to health care services and are responsive to a ~~member's~~Member's cultural and linguistic needs. These services include, but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to ~~interpreter~~Interpreter services at key points of contact for all ~~members~~Members; 3. Providing translations of informational materials in threshold languages, providing oral translation for other languages upon request or as needed, and providing information and materials to meet the needs of ~~members~~Members with sensory impairments; and 4. Referring ~~members~~Members to culturally and linguistically appropriate community services, as needed.
Cultural and Linguistic Services Work Plan	An annual work plan included in the PNA, which incorporates and reflect findings from the PNA Report and annual PNA Update. The Work Plan shall include implementation activities, timelines with milestones, responsible individuals, and the individual with overall responsibility.

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Term	Definition
Cultural Competency	The ability to actively apply knowledge of cultural behavior and linguistic issues when interacting with ~~members~~Members from diverse cultural and linguistic backgrounds. Essential elements of Cultural Competency include: 1. An unbiased attitude and organizational policy that values and respects cultural diversity and respect for the multifaceted nature and individuality of ~~members~~Members; 2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about preventive health, illness and diseases, as well as differing communication patterns; 3. Recognition of the diversity among ~~members~~Members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual orientation, social and historical context, generational, and acculturation status); 4. Skills to communicate effectively with diverse Member populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care; 5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability; 6. Programs and policies that address the health needs of diverse ~~member~~Member populations; and 7. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of ~~members~~Members.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Emergency Services	Covered ~~Services~~inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
~~Population Needs Assessment (PNA)~~Grievance	~~An evaluation which identifies member health status and behaviors, member health education and C&L needs, health disparities, and gaps in services related to these issues~~An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.
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 to provide covered services to ~~members~~Members assigned to that ~~health network~~Health Network.

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Term	Definition
Interpreter	A person who renders a message spoken in one language into one or more languages. An interpreter must be qualified per requirements outlined in WIC 14029.91(a)(1)(B) and 45 CFR 92.101(b)(3).
Key Points of Contact	Service sites for ~~members~~Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with providers that provide medical or health care services and advice to ~~members~~Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or ~~member~~Member orientation meetings.
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 program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and ~~members~~Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting ~~members~~Members.
Member Information	Documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to, the Member Handbook/Evidence of Coverage; provider directory; welcome packets; marketing information; form letters, including Notice of Action letters and any notices related to Grievances, actions, and Appeals, including Grievance and Appeal acknowledgement and resolution letters; plan generated preventive health.
Population Needs Assessment (PNA)	An evaluation which identifies Member health status and behaviors, Member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, ~~health maintenance organization,~~ or other person or institution that furnishes ~~covered services~~Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of providers, representing a cross-section of the broad provider community that serves ~~members~~Members, established by CalOptima to advise its Board of Directors on issues impacting the CalOptima provider community.
Qualified Interpreter	An Interpreter who: 1) has a demonstrated proficiency in speaking and understanding both English and the language spoken by the limited English proficient (LEP) individual; 2) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary, terminology, and phraseology; and 3) adhere to generally accepted interpreter ethics principles, including client confidentiality.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an first tier, downstream or related entity's, or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

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Term	Definition
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Care	An episodic physical or mental condition perceived by a managed care beneficiary as serious but not life threatening that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.
Written Translation	The replacement of written text from one language into another.

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Policy:	DD.2002
Title:	**Cultural and Linguistic Services**
Department:	Customer Service
Section:	Not Applicable
Interim CEO Approval:	*/s/*
Effective Date:	10/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy ensures effective communication to Members regarding treatment, diagnosis, medical history, and health education by providing culturally, linguistically, and appropriate services to all Members, taking into consideration Members' beliefs, traditions, customs, and individual differences.

II. POLICY

A. CalOptima and its Health Networks shall provide culturally and linguistically appropriate services to Members. Specifically, CalOptima and its Health Networks shall:

1. Recruit bilingual employees for appropriate positions whenever possible, and enhance employees' bilingual skills and cultural sensitivity through employee development programs, as needed;

2. Provide, at no cost to the Member, twenty-four (24) hour access to Qualified Interpreter services at Key Points of Contact;

3. Provide, at no cost to the Member, translations of Member informational materials in Threshold Languages, oral translation for other languages upon request or as needed, by a qualified translator, and information and materials to meet the needs of Members with sensory and hearing impairments;

4. Adhere to Department of Health Care Services (DHCS) requirements for determining language threshold; and

5. Refer Members to culturally and linguistically appropriate community services, as needed.

B. CalOptima shall establish a Member Advisory Committee (MAC) comprised of community advocates and Members representing a cross-section of the CalOptima Member population, as defined by CalOptima Board Resolution Numbers 2-14-95 (effective February 14, 1995), 11-1103 (effective November 3, 2011), and 15-08-06-02 (effective July 1, 2015). The MAC shall meet the Community Advisory Committee requirements and shall be overseen by the Executive Director of Operations. The MAC shall provide information and recommendations with respect to CalOptima's

Cultural and Linguistic Services and shall collaborate with the CalOptima Provider Advisory Committee (PAC) with regard to Cultural and Linguistic Services on an ad hoc basis.

C. CalOptima and its Health Networks shall comply with applicable Federal and State civil rights laws, including, but not limited to, Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, and do not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.

1. CalOptima and its Health Networks shall post notices of non-discrimination, in at least twelve (12)-point font, in accordance with requirements set forth by the DHCS.

2. CalOptima and its Health Networks shall include a notice of non-discrimination on written Member-informing materials, and in all informational notices targeted to Members, potential enrollees, and the public, in accordance with requirements set forth by the DHCS.

D. CalOptima shall monitor Member Grievances, report Grievances related to Cultural and Linguistic Services, and shall designate a discrimination grievance coordinator who is responsible for ensuring compliance with Federal and State nondiscrimination requirements for appropriate action, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

E. The Office of Compliance shall perform annual audits to ensure CalOptima and its Health Networks are in compliance with cultural and linguistic regulatory requirements and may impose Sanctions and/or a Corrective Action Plan (CAP), in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

III. PROCEDURE

A. On an annual basis, CalOptima shall identify health education and cultural and linguistic needs by conducting a Population Needs Assessment (PNA) to facilitate the development of programs and services. CalOptima shall:

1. Provide the MAC an opportunity to provide comment on the PNA;

2. Report PNA findings to the MAC;

3. Discuss improvement opportunities; and

4. Update the MAC on progress made to PNA goals.

B. PNA and Cultural and Linguistic Services Work Plan

1. CalOptima and its Health Networks shall develop a Cultural and Linguistic Services Work Plan and shall designate a professional, the cultural and linguistic manager, who has expertise in Cultural and Linguistic Services to be responsible for planning, managing, and evaluating activities conducted under the Work Plan and shall oversee cultural and linguistic staff as specified in Attachment A. The Cultural and Linguistic Services Work Plan shall be reviewed annually and updated as needed.

2. CalOptima shall assign a professional who is trained and has expertise in health education or community health to conduct the PNA. This professional shall be responsible for coordinating with CalOptima Cultural and Linguistic Services and Health Education Department staff to

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implement effective health education and cultural and linguistic programs resulting from the PNA, and for reporting on the PNA and related activities to the Quality Improvement Committee, as required.

3. CalOptima shall develop a Cultural and Linguistic Services Work Plan to provide appropriate services to meet the needs of Members. The Cultural and Linguistic Services Work Plan shall address the needs identified in the PNA and shall be submitted to DHCS, as required.

4. CalOptima's cultural and linguistic Manager shall annually present the cultural and linguistic goals and objectives to the MAC and PAC and shall request input on the implementation of Cultural and Linguistic Services Work Plan.

C. Employee Recruitment and Development

1. CalOptima and its Health Networks shall make best efforts to recruit qualified culturally, sensitive and bilingual employees, especially for positions that require direct Member communication.

2. CalOptima and its Health Networks shall assess the language capability of an employee to determine the employee's proficiency level for an assignment that includes the use of bilingual skills.

3. CalOptima and its Health Networks shall enhance an employee's ability to communicate managed care and medical care terminology to Members in their preferred language through training and development programs.

4. CalOptima and its Health Networks shall provide comprehensive staff training to ensure a Member with a sensory impairment is assisted in accessing information, services, and benefits.

5. CalOptima and its Health Networks shall encourage employees to attend cultural sensitivity seminars and workshops offered by CalOptima, professional organizations, universities, or colleges in order to develop Cultural Competency, including, but not limited to:

   a. Developing attitudes that value and respect diversity;

   b. Enhancing knowledge and awareness of beliefs, behaviors, and preventive health practices;

   c. Acquiring skills to communicate with Members with diverse language needs, including sign language interpreter services; and

   d. Developing the ability to address the health needs of diverse populations.

D. CalOptima and its Health Networks shall assess, identify, and report the linguistic capabilities of Interpreters, bilingual employees, and Contracted Providers by:

1. Providing verification that a multiple-step process is used in the recruitment and hiring process of Interpreters and bilingual employees.

   a. Such process shall include technical qualification testing, bilingual, interpreting, and/or translation proficiency testing and background check.

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2. Testing and continually training Interpreters, translators, bilingual employees, and Contracted Providers.

3. Annually, or upon request, providing training and certification verification of their Interpreters, translators, bilingual employees, and Contracted Providers.

E. CalOptima and its Health Networks shall provide language assistance services, free of charge, for Members who speak a language other than English and shall:

1. Include language taglines, compliant with requirements set forth by the DHCS, on Member-informing materials, such the Notice of Privacy Practices.

2. Include translation and oral interpretation and large print taglines no smaller than twenty (20)-point font, and explain how to request free language assistance services and auxiliary aids and services.

3. Ensure equal access to health care service for its Members and potential members without regard to a Member's proficiency in the English language. CalOptima will provide Interpreter services adequate to communicate the medical, social, and psychological issues of its Members, when necessary, in compliance with federal and state law, and DHCS All Plan Letter (APL) 20-015: State Non-Discrimination and Language Assistance Requirements.

F. CalOptima and its Health Networks shall ensure Members receive information in Threshold Languages regarding a Member's right to file a Grievance. Grievance forms and procedures shall be readily available to Members in Threshold Languages, and in alternative formats, such as large print in at least twenty (20) point size font, braille or audio format, upon request or as needed. Oral interpretation shall also be available to help the Member understand the information provided.

G. Interpreter Services and Access for Members with Sensory Impairments

1. CalOptima and its Health Networks shall provide Members with linguistic Interpreter services, American Sign Language (ASL) Interpreter services, and information about the Teletypewriter (TTY) or California Relay Service (CRS) to Members with hearing or speech impairments. CalOptima and its Health Networks shall provide primary consideration to the individual's request of a particular auxiliary aid or service such as Members with visual, hearing and speech impairments, as necessary, to ensure effective communication regarding treatment, diagnosis, medical history, or health education. Interpretation can take place in-person, through a telephonic Interpreter, or via internet or video remote interpreting (VRI) services. VRI services, must provide real-time motion video and audio over a dedicated high-speed, wire-bandwidth video connection that delivers high-quality video images that do not produce lags, choppy, blurry or grainy images, or irregular pauses in communication; a sharply delineated image that is large enough to display the interpreter's face, arms, hand, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position; a clear, audible transmission of voices; and adequate training of users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

a. CalOptima and its Health Networks shall provide, at no cost to the Member, twenty-four (24)-hour access to Interpreter services at Key Points of Contact.

b. When providing interpretive services, CalOptima and its Health Networks shall use Qualified Interpreters to interpret for an individual with a disability, whether through a remote interpreting service or an on-site appearance.

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c. CalOptima and its Health Networks shall educate Providers regarding the process to access no-cost Interpreter services for Members.

d. CalOptima and its Health Networks shall provide notice of no cost Interpreter services through the CalOptima Member Handbook and other communications, including, but not limited to posters and flyers distributed at sites where Members receive Covered Services, Member newsletters and at Member orientation sessions.

e. If a Member or Provider requests an Interpreter in a situation where Covered Services are needed, CalOptima or the Member's Health Network shall provide an Interpreter in time to adequately assist with all necessary care, including Urgent Care and Emergency Services.

f. When possible, and appropriate, CalOptima and its Health Networks shall make all reasonable efforts to ensure assignment of the same face-to-face Interpreter to Members who require follow-up care.

g. CalOptima and its Health Networks shall utilize a vendor for telephone Interpreter services for languages not spoken by bilingual employees, for Urgent Care and Emergency Services or as needed. CalOptima and its Health Networks are prohibited from using remote audio or VRI services that do not comply with federal quality standards, or relying on unqualified bilingual/multilingual staff, Interpreters, or translators.

h. CalOptima and its Health Networks may schedule Face-to-face Interpreter services, including ASL Interpreter services, through a contracted vendor.

i. CalOptima and its Health Networks shall utilize the TTY, the CRS, or a comparable device or service available to assist Members with a hearing or speech impairment.

j. CalOptima, its Health Networks, and Contracted Providers shall ensure that Members with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the need of the Member and include, but are not limited to, individualized assistance, note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.

k. CalOptima and its Health Networks shall make informational or educational materials readily available to Members in Threshold Languages, and in alternative formats, such as large print in at least twenty (20) point size font, braille or audio format, upon request or as needed, at no cost to the Member, within twenty-one (21) calendar days upon receipt of request. CalOptima and its Health Networks shall inform Members of the availability of these materials through the Member Handbook/EOC booklet and other mechanisms, including, but not limited to, posters and flyers distributed at sites where Members receive Covered Services and at Member orientation sessions.

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l. CalOptima and its Health Network shall enable Members to make a standing request to receive all informing material in a specified alternative format.

m. CalOptima and its Health Networks and Providers shall document a Member's language needs in the Member's file. Documentation in the Member's file shall include the Member's request or refusal of Interpreter services.

2. CalOptima and its Health Networks shall not require or suggest to a Member to use friends or family Members, particularly minors, as interpreters. A Member's friend or family Members may be used as interpreters if the following conditions are met:

a. The Member is advised that an Interpreter is available at no cost to the Member;

b. It is requested by the Member;

c. It will not compromise the effectiveness of service; and

d. It will not violate the Member's confidentiality.

e. In an emergency only, a minor child may be used as an interpreter if requested by the Member.

3. CalOptima and its Health Networks shall inform Members of their right to file a complaint if a Member fails to receive Interpreter services, in accordance with CalOptima Policies HH.1102: Member Grievance and HH.1103: Health Network Member Grievance and Appeal Process.

H. Translation Services

1. CalOptima and its Health Networks shall provide, at no cost to the Member, translation of written informing documents in Threshold Languages and concentration languages identified by DHCS. Written informing documents provide essential information regarding access and usage of Covered Services, and include, but are not limited to:

a. Member Handbook/EOC booklet;

b. Member Consent forms;

c. Disclosure forms;

d. Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a Grievance or Appeal;

e. Provider listings or directories;

f. Marketing materials;

g. Notices advising limited-English-proficient persons of the availability of free language assistance;

h. Form letters;

i. Preventive health reminders; and

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j. Member surveys and newsletters.

2. CalOptima and its Health Networks shall provide, upon a Member's request, a Written Translation of a non-standardized Member-specific document into Threshold Language within twenty-one (21) calendar days.

3. To ensure the quality of the translation, CalOptima and its Health Networks shall select qualified translators when translating written content in paper or electronic form, have an editor for translated documents, and provide for legal review of legal documents. The process shall include having the translated documents translated back to English to ensure the accuracy of the translation.

4. To ensure non-English translations of documents meet the same standards as the English versions, translated documents shall conform to the same document standards as the English versions, which may include but is not limited to, reading level and font size.

5. CalOptima and its Health Networks shall provide translations of written informing documents at a reading level no higher than sixth (6th) grade, or that is appropriate, as determined by other processes such as Field-Testing or the PNA, to the extent that compliance with the requirement does not conflict with regulatory agency directives or other legal requirements.

I. Cultural Competency Training and Education

1. CalOptima and its Health Networks shall provide initial and continuing training to Contracted Providers on Cultural Competency issues. CalOptima and its Health Networks may:

a. Conduct the training in conjunction or collaboration with other Health Networks or with CalOptima; or

b. Work with community organizations or educational institutions to provide the training.

J. Referral to Culturally and Linguistically Appropriate Services

1. CalOptima and its Health Networks shall develop working relationships with community-based and faith-based organizations and shall refer a Member to culturally and linguistically appropriate community services, as needed.

K. Monitoring and Evaluation of C&L Services

1. A Health Network shall provide culturally and linguistically appropriate services to all Members, pursuant to the CalOptima Contract for Health Care Services, as well as applicable state and federal regulations.

2. CalOptima shall delegate to a Health Network the responsibility for monitoring the language capability of Contracted Providers listed as speaking specific languages in the Provider Directory. At a minimum, a Health Network shall:

a. Document whether it is the Provider or the office staff who has the language skill(s).

i. This information must be updated at least annually.

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b. Develop procedures for assessing Interpreters' language proficiency.

3. CalOptima, in consultation with its Health Networks, shall establish cultural and linguistic service standards. Using the cultural and linguistic service standards, CalOptima shall monitor and evaluate a Health Network's provision of Cultural and Linguistic Services, in accordance with CalOptima Policy GG.1619: Delegation Oversight as follows:

   a. Review the Health Network's cultural and linguistic policies and procedures;

   b. Review the Health Network's translated written informing documents, such as Member Handbooks, denial letters, consent forms, newsletters, outreach flyers and brochures, complaints and Grievance forms, and health education materials;

   c. Review the Health Network's documentation of efforts to recruit and retain bilingual employees;

   d. Review the Health Network's testing and training requirements for employees who utilize bilingual skills to assist Members;

   e. Review the Health Network's process for monitoring the language capability of Contracted Providers listed as speaking specific languages in the Provider Directory;

   f. Review the Health Network's training curriculum, schedules, and sign-in sheets to assess the training effort;

   g. Review the Health Network's community resource list to evaluate Member referrals to culturally and linguistically appropriate services; and

   h. Identify and monitor complaints and Grievances related to C&L Services.

4. CalOptima shall monitor and evaluate Health Network's training and education of Providers and staff, regarding the process of accessing Interpreter services for Members. The Health Networks shall:

   a. Provide initial and continuous training and education to Contracted Providers and staff on the process to access Interpreter services for Members.

   b. Annually, or upon request, provide verification of initial and continuous training.

   c. CalOptima shall perform audit test calls to Health Networks to determine the process for accessing Interpreter services for Members and verifying that the process is appropriate for meeting Member's needs.

5. The Office of Compliance shall record the results of its assessment and evaluation of a Health Network's provision of Cultural and Linguistic Services using an audit tool and shall communicate the results to the Compliance Committee and the Health Network for appropriate action.

IV. ATTACHMENT(S)

A. Cultural and Linguistic Services Qualifications and Structure
B. Notice of Non-Discrimination and Language Tagline (Medi-Cal)

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V. REFERENCE(S)

A. CalOptima Board Resolution 15-08-06-02
B. CalOptima Board Resolution 11-11-03
C. CalOptima Board Resolution 2-14-95
D. CalOptima Contract for Health Care Services
E. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
F. Cultural and Linguistic Services Plan
G. CalOptima Member Handbook/Evidence of Coverage (EOC)
H. CalOptima Policy GG.1201Δ: Health Education Programs
I. CalOptima Policy GG.1619: Delegation Oversight
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. CalOptima Policy HH.1104: Complaints of Discrimination
M. CalOptima Policy HH.2002Δ: Sanctions
N. CalOptima Policy HH.2005Δ: Corrective Action Plan
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-011: Health Education and Cultural and Linguistic Population Needs Assessment
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-015: State Non-Discrimination and Language Assistance Requirements
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (supersedes APL 17-011 and Policy Letters 99-003 and 99-004)
R. National Committee for Quality Assurance Standard – Element A: QI Program Structure, Factor 8 Objectives for serving a culturally and linguistically diverse membership
S. Title 42, Code of Federal Regulations (CFR), §438.10(d)
T. Title 45, Code of Federal Regulations (CFR), §84.52
U. Title 22, Code of California Regulations, §§53876 and 53895

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/01/2015	Department of Health Care Services (DHCS)	Approved as Submitted
02/29/2016	Department of Health Care Services (DHCS)	Approved as Submitted
09/10/2020	Department of Health Care Services (DHCS)	Approved as Submitted
12/13/2021	Department of Health Care Services (DHCS)	Approved as Submitted

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	10/01/1998	DD.1107	Cultural and Linguistic Services	Medi-Cal
Revised	03/01/2000	DD.1107	Cultural and Linguistic Services	Medi-Cal
Revised	07/01/2000	DD.1107	Cultural and Linguistic Services	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2004	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	08/01/2008	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	10/01/2011	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	01/01/2013	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	01/01/2014	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	12/01/2014	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	12/01/2015	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	08/01/2016	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	07/01/2017	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	12/01/2017	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	01/01/2019	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	02/01/2020	DD.2002	Cultural and Linguistic Services	Medi-Cal
Revised	TBD	DD.2002	Cultural and Linguistic Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima, its contracted Health Networks or Physician Medical Groups.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. First tier, downstream and related entities, and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Services	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's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

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Term	Definition
Cultural and Linguistic Services	Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to Interpreter services at key points of contact for all Members; 3. Providing translations of informational materials in threshold languages, providing oral translation for other languages upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and 4. Referring Members to culturally and linguistically appropriate community services, as needed.
Cultural and Linguistic Services Work Plan	An annual work plan included in the PNA, which incorporates and reflect findings from the PNA Report and annual PNA Update. The Work Plan shall include implementation activities, timelines with milestones, responsible individuals, and the individual with overall responsibility.
Cultural Competency	The ability to actively apply knowledge of cultural behavior and linguistic issues when interacting with Members from diverse cultural and linguistic backgrounds. Essential elements of Cultural Competency include: 1. An unbiased attitude and organizational policy that values and respects cultural diversity and respect for the multifaceted nature and individuality of Members; 2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about preventive health, illness and diseases, as well as differing communication patterns; 3. Recognition of the diversity among Members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual orientation, social and historical context, generational, and acculturation status); 4. Skills to communicate effectively with diverse Member populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care; 5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability; 6. Programs and policies that address the health needs of diverse Member populations; and 7. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of Members.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

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Term	Definition
Emergency Services	Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.
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 to provide covered services to Members assigned to that Health Network.
Interpreter	A person who renders a message spoken in one language into one or more languages. An interpreter must be qualified per requirements outlined in WIC 14029.91(a)(1)(B) and 45 CFR 92.101(b)(3).
Key Points of Contact	Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.
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 program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Member Information	Documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to, the Member Handbook/Evidence of Coverage; provider directory; welcome packets; marketing information; form letters, including Notice of Action letters and any notices related to Grievances, actions, and Appeals, including Grievance and Appeal acknowledgement and resolution letters; plan generated preventive health.
Population Needs Assessment (PNA)	An evaluation which identifies Member health status and behaviors, Member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues
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.
Provider Advisory Committee (PAC)	A committee comprised of providers, representing a cross-section of the broad provider community that serves Members, established by CalOptima to advise its Board of Directors on issues impacting the CalOptima provider community.

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Term	Definition
Qualified Interpreter	An Interpreter who: 1) has a demonstrated proficiency in speaking and understanding both English and the language spoken by the limited English proficient (LEP) individual; 2) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary, terminology, and phraseology; and 3) adhere to generally accepted interpreter ethics principles, including client confidentiality.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an first tier, downstream or related entity's, or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Care	An episodic physical or mental condition perceived by a managed care beneficiary as serious but not life threatening that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.
Written Translation	The replacement of written text from one language into another.

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Cultural & Linguistic Services Qualifications and Structure

Director, Customer Service

Job Summary

- Provide leadership, in the day-to-day management, strategic direction and support to the CalOptima's Customer Services operations; Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic, Member Communications, Enrollment & Reconciliation, Member Advisory Committees and CalOptima Member Portal.
- Guide staff in the implementation of strategic and tactical direction to improve efficiencies to ensure high quality and responsive service to members, providers, contracted vendors and regulatory agencies. The incumbent will regularly interact with all levels of internal CalOptima staff; as well as, external contacts with regulatory agencies, health networks, community-based organizations, and medical groups.

Experience & Education

- Bachelor's degree in Business or related field; and/or equivalent work experience is required. Note equivalent work experience in lieu of a Bachelor's degree will be approved by HR and the hiring manager.
- 7 years' experience overseeing the day to day operations of a call center within a health plan, health network, medical group, TPA or MSO.
- 5 years supervisory experience required.
- 5 years of health care management experience, HMO, Medi-Cal/Medicaid, insurance, preferably in managed care environment in related area of responsibility required, i.e. utilization management, quality management, grievances and appeals.
- Relevant government client or public service experience preferred.

Knowledge of:

- Principles and methods of planning, directing and maintaining compliance with eligibility determination and service standards.
- Techniques and methods to organize and manage a department.
- Applicable knowledge of state and federal healthcare regulations.
- Principles and practices of health care service delivery, managed care, health care systems, and medical administration.
- Appropriate techniques to serve diverse social and ethnic groups and to communicate effectively with them.
- Principles and techniques of effective supervision, including training and evaluation of subordinates.
- Systems and procedures to efficiently operate the enrollment process and promote a high rate of member choice of health plan.

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- Medi-Cal, Medicare, Healthy Families, and OneCare Program services, regulations and benefits, including State and Federal standards and regulations for member and provider rights and responsibilities.
- Knowledge and understanding of covered benefits specified in CalOptima contracts.
- Principles and practices of the managed health care systems, and medical administration.
- Appropriate techniques to serve diverse social and ethnic groups.

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Manager, Cultural & Linguistics

Job Summary

- Manage the daily operations of CalOptima's Member Communications and Cultural and Linguistics Programs. Responsible for all aspects of planning, developing, implementing, and oversight of projects in these areas.
- Oversight of the daily C&L services activities with guidance from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC).
- Present the C&L Goals and Objectives to the MAC and PAC and requesting input and guidance on the implementation of C&L initiatives.
- Responsible for all aspects of planning, developing, implementing, and oversight of projects in these areas. These responsibilities include the accurate and timely production and maintenance of member materials and notices developed in compliance with appropriate regulatory agency requirements
- Responsible for carrying out local and Federal government Cultural and Linguistics regulatory requirements as they pertain to CalOptima.
- Oversee the accurate and timely delivery of document translations and interpretive services, and the organization of culturally educational events, and other related projects as needed.

Experience & Education

- Relevant Bachelor's degree, such as Health Care Administration.
- Master's degree desired.
- Strong writing, analytical and oral presentation skills.
- Must be comfortable working in a dynamic environment with both short-term and long-term deadlines.
- Bilingual in English and either Spanish or Vietnamese preferred.
- 2-3 years of previous supervisory experience.

Knowledge of:

- Culture and needs of the socially and ethnically diverse population CalOptima serves.
- Principles and practices of health care, health care systems, and managed care.
- Principles and techniques of effective administration and supervision, including training and evaluation.
- Medi-Cal benefits and regulations.
- Techniques of program and policy development, administration and coordination.
- Health Plan, Hospital and Medical Group operations and strategies.

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Program Specialist (Member Communications)

Job Summary

- Provide specialized assistance and analysis relevant to member communications.
- Interface and works collaboratively with internal staff and external vendors and agencies; creates and/or reviews member communication materials; and researches and identifies issues and solutions relative to member communications for all lines of business.

Experience& Education:

- Bachelor's degree in Business or related field; or equivalent combination of education and work experience is required.
- 2+ years of experience or training in a managed care environment required.
- Cultural and linguistic studies or printing management preferred.
- Bilingual in English and in one of CalOptima's defined threshold languages is preferred.
- Knowledge of Medi-Cal highly preferred.
- A combination of experience and education in the area of assignment, which would provide the knowledge and abilities listed is required.

Knowledge of:

- Policies, regulations and general requirements related to member communications.
- Practices and techniques required to function with professionals working in the communications.
- Methods and techniques for organizing and implementing processes.
- General information relevant to professional or administrative responsibilities in the assigned program.

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Program Specialist (Translations & Interpreter Services)

Job Summary

- Support CalOptima's compliance with cultural and linguistic (C&L) State and Federal regulatory requirements.
- Assist in the development and/or implementation of cultural and linguistic services/activities, such as: 1) providing and coordinating professional translation and review services in one of CalOptima's threshold languages; 2) coordinating interpreter services of non-English languages and American Sign Language; 3) planning and organizing cultural competency training; and 4) researching and analyzing issues and making recommendations to enhance CalOptima's cultural and linguistic program and services.
- Plan, organize and develop cultural competency trainings for CalOptima staff, providers, contracted health networks and community-based organizations.
- Provide and coordinate professional and timely translations and/or reviews of CalOptima member materials.
- Ensure the timely delivery of interpreter services by working with qualified staff interpreters and contracted interpreter service vendors.
- Review, research, resolve and trend member complaints and/or grievances related to cultural and language issues.
- Represent the department and facilitate communications on cultural and linguistic services within, or outside CalOptima.
- Identify cultural and/or linguistic barriers to members accessing health care services and health disparities where appropriate.

Experience & Education

- Bachelor's degree in a health care related field or cultural and linguistic studies is preferred.
- Professional education in the area of translation, interpretation and cultural competency training is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language is required.
- 1+ years of experience with a health plan, program or clinical environment working with culturally diverse populations is required.
- Experience in managed care and/or government programs preferred.

Knowledge of:

- Policies, regulations and general requirements of cultural and linguistic services.
- Principles and practices of health care, health care service delivery and medical administration.
- Experience addressing issues of cultural and linguistic competency and racial and ethnic disparities in health care.
- Orange County community based and social service organizations, especially those providing support services and health education to Limited Education Proficient (LEP) members of the community.
- General information relevant to professional or administrative responsibilities in the assigned program.

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Supervisor, Customer Service (Cultural Linguistics)

Job Summary

- Responsible for overseeing the daily operation of the department and supervision of the Cultural and Linguistic (C&L) staff.
- Responsible for staying current on the latest federal and state C&L requirements and other regulations that may affect the department. This position will provide coach and provide guidance to the staff to effectively resolve problems.
- Monitor translation and interpretation activities and staff calls according to the different language needs and provides feedback to staff in a timely manner.
- Perform periodic auditing of translation and interpreter services to ensure C&L quality standards are met.
- Participate in internal and external workgroups, committees, and collaborates to provide organizational guidance on issues related to C&L Services.

Experience & Education

- Bachelor's degree in health care, health administration, cultural and linguistic studies or other related area of study; or equivalent combination of education and work experience is required.
- 2+ years of experience with a health plan, program or clinical environment working with culturally diverse populations.
- 3 years of lead or supervisory experience required.
- Professional education or experience in the area of translation, interpretation and cultural competency training is preferred.
- Knowledge of print management, printing, fulfillment or direct mailing is preferred.
- Experience in managed care and/or government programs.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Knowledge of:

- Policies, regulations and general requirements of cultural and linguistic services.
- Principles and practices of healthcare, healthcare service delivery and medical administration.
- Experience addressing issues of cultural and linguistic competency and racial and ethnic disparities in healthcare.
- Orange County community based and social service organizations, especially those providing support services and health education to Limited Education Proficient (LEP) members of the community.
- General information relevant to professional or administrative responsibilities in the assigned program.

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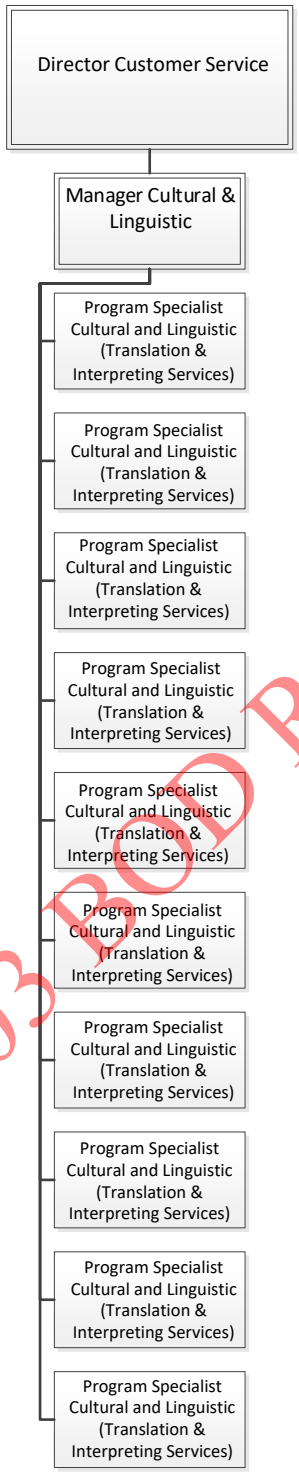

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NONDISCRIMINATION NOTICE

Discrimination is against the law. CalOptima follows Federal civil rights laws. CalOptima does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CalOptima provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact CalOptima at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. Or, if you cannot hear or speak well, please call TTY/TDD at **1-800-735-2929**.

HOW TO FILE A GRIEVANCE

If you believe that CalOptima has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CalOptima. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CalOptima between 8 a.m. and 5:30 p.m. by calling toll-free at **1-888-587-8088**. Or, if you cannot hear or speak well, please call TTY/TDD at **1-800-735-2929**.
- In writing: Fill out a complaint form or write a letter and send it to:

  CalOptima Grievance and Appeals
  505 City Parkway West
  Orange, CA 92868

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- In person: Visit your doctor's office or CalOptima and say you want to file a grievance.
- Electronically: Visit CalOptima's website at **www.caloptima.org**.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call TTY/TDD **1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

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Language Assistance

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1-888-587-8088** (TTY: **1-800-735-2929**).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-587-8088** (TTY: **1-800-735-2929**).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-587-8088** (TTY: **1-800-735-2929**).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-587-8088** (TTY: **1-800-735-2929**).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-587-8088** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-587-8088**（TTY：**1-800-735-2929**）。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-888-587-8088** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-587-8088** (телетайп: **1-800-735-2929**).

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فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-888-587-8088** (TTY: **1-800-735-2929**) تماس بگیرید.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけ
す。**1-888-587-8088**（TTY: **1-800-735-2929**）まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-888-587-8088** (TTY: **1-800-735-2929**).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-888-587-8088** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-587-8088** (رقم هاتف الصم والبكم: **1-800-735-2929**).

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-587-8088** (TTY: **1-800-735-2929**) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-888-587-8088** (TTY: **1-800-735-2929**).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-888-587-8088** (TTY: **1-800-735-2929**)។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-888-587-8088** (TTY: **1-800-735-2929**).

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
10. Approve Changes to CalOptima Provider Network Policies

Contact
Yunkyung Kim, Chief Operating Officer 714-246-8408

Recommended Actions
Approve the following actions related to CalOptima Provider Network policies:

1. Modifications to Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory;
2. Modifications to Policy EE.1103: Provider Network Training;
3. Retirement of Policy EE.1114: Health Network Notification of Change in Name, Management Company, Key Personnel, or Operating System; and
4. New Policy EE.1116: Contracted Provider Changes Affecting the Legal Status of the Contract; and
5. New Policy EE.1119: Health Network Notification of Administrative and Operational Changes

Background & Discussion
CalOptima staff regularly reviews agency Policies and Procedures to ensure that they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations, and laws as well as CalOptima Operations. Staff also initiates reviews of policies in response to findings from internal and external audits.

Below is a description of the impacted policies, followed by a list of recommended substantive changes to each policy, which are reflected in the attached redlines. The list does not include non-substantive changes that may also be reflected in the redline (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

1. **EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory** outlines the process for adding, changing, or terminating a provider in the CalOptima Provider Directory and Web-based Directory.

Policy Section	Change
III.A.5	Updated Taxonomy as a data element to include in provider directories
III.C.1,2 and 3	Added timeframes for providers to submit requests to add, change or terminate a provider to CalOptima.
III.C.3	Added CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services as a reference
III.F.1	Allows provider to notify CalOptima of changes through electronic notification with applicable data
IV.C.	Added National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy Code Set to list of attachments

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2. **EE.1103: Provider Network Training** outlines education requirements for newly contracted providers and annual training for all providers. This includes, but is not limited to, timelines for completing training, attestation requirements, types of training,

Policy Section	Proposed Change
II.F. (prior Section II.G.)	Added requirement for CalOptima and Health Networks to provide out-of-network providers who will not receive Network Provider training, with clinical protocols, evidence-based practice guidelines and the Special Needs Plan (SNP) Model of Care
II.G.	Added requirement for PACE providers to complete training prior to serving PACE participants
III.F.1.a-c	Added requirement for documentation of training for employees

3. **EE.1114: Health Network Notification of Change in Name, Management Company, Key Personnel, or Operating System(s)** outlines the requirements for a Health Network or Delegated Entity to notify CalOptima of a change in the Health Network or Delegated Entity's name, management company key personnel, or operating systems.

   To clarify department roles and responsibilities, staff recommend retiring EE.1114, and separating it into two policies to align by operational roles and responsibilities. The new proposed policies are:
   - EE.1116: Contracted Provider Notification to CalOptima of Changes Affecting the Legal Status of the Contract; and
   - EE.1119: Health Network Notification of Administrative and Operational Changes.

4. **EE.1116: Contracted Provider Notification to CalOptima of Changes Affecting the Legal Status of the Contract** describes the process for a contracted provider to notify CalOptima of changes affecting the legal status of their contract and how such changes are managed by CalOptima. Provider changes are communicated to CalOptima in accordance with the timeframes specified in the terms of their contract. Examples include, but are not limited to:
   - Changes in legal name or "doing business as" (DBA) name;
   - Change in ownership;
   - Change in National Provider Identifier (NPI) and/or Tax Identification Number (TIN);
   - Changes in availability or location of services (i.e., closure of company or location(s) that are listed in provider's contract; new location); and
   - Retirement or death of a professional that has an individual contract.

5. **EE.1119: Health Network Notification of Administrative and Operational Changes** describes the process and requirements for a health network or delegated entity to report administrative or operational changes to CalOptima, and how such changes are managed by CalOptima. Examples include, but are not limited to:
   - Changes in management service organization (MSO);
   - Changes in systems impacting operations or reporting;
   - Changes in address, phone number, or email domain; and
   - Changes in key personnel.

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To ensure CalOptima's provider information and directories are clear, compliant, and up-to-date with current operations, staff requests Board approval of the above policy changes to CalOptima Policies EE.1101 and EE.1103, retirement of EE.1114, and approval of EE.1116 and EE.1119.

Fiscal Impact
The recommended actions are operational in nature and have no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation
The policy changes as well as new policies provide additional clarity, align policies with current operations, and allows CalOptima and its providers to comply with state and federal program requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. EE.1101 PRC-Approved Draft Policy (Redlined and Clean Versions)
2. EE.1103 PRC-Approved Draft Policy (Redlined and Clean Versions)
3. EE.1114: PRC-Approved Draft Policy (Redlined and Clean Versions)
4. EE.1116: PRC-Approved Draft Policy (Redlined and Clean Versions)
5. EE.1119: PRC-Approved Draft Policy (Redlined and Clean Versions)

Board Actions
None

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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Policy:	EE.1101Δ
Title:	**Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory**
Department:	Network Operations
Section:	Provider Relations
Interim CEO Approval:	
Effective Date:	11/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

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I. PURPOSE

This policy outlines the process for adding, changing, or terminating a Provider in the CalOptima Provider Directory and Web-based Directory.

II. POLICY

A. For each CalOptima program, CalOptima shall publish a printed hardcopy and online PDF version of the Provider Directory on a monthly basis, and a Web-based Directory that is updated within forty-eight (48) hours of an Addition, Change, or Termination of a Provider.

B. The Provider Directory shall include information on Health Networks ~~and~~, hospitals, Primary Care Providers (PCPs), OB/GYNs, specialists, behavioral health ~~providers~~Providers, managed long-term services and support (MLTSS) Providers, urgent care centers, ancillary ~~providers~~Providers, Facilities, and pharmacies who are credentialed and contracted with CalOptima directly or through a subcontracted agreement with a Health Network.

C. CalOptima shall ensure the printed hardcopy and online PDF version of the Provider Directory address Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) requirements for Provider Directories.

D. CalOptima shall submit the Medi-Cal Provider Directory to DHCS every six (6) months and shall include a PDF with the submission which DHCS can use for distribution, as needed.

E. CalOptima and Health Networks shall report changes to information for a Provider or Facility in the CalOptima Provider Directory and Web-based Directory on an ongoing basis in accordance with this Policy.

F. CalOptima, Health Networks, Delegated Provider Groups, and Providers shall validate their directory information on a semi-annual basis in accordance with this Policy.

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G. CalOptima shall ensure the Web-based Provider Directory is made available in a machine-readable file and format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.

III. PROCEDURE

A. CalOptima shall publish a Provider Directory for each CalOptima program and a Web-based Directory that includes, but is not limited to, the following information to help existing and prospective Members choose physicians:

1. Headers to indicate city or region names (in alphabetical order);

2. Name;

3. Gender;

4. Specialty;

5. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

~~5.~~6. Area of focus, if applicable;

~~6.~~7. National Provider Identifier (NPI);

~~7.~~8. Hospital affiliation(s);

~~8.~~9. Primary care clinic or Medical Group affiliations, if applicable;

~~9.~~10. Board certification, if applicable;

~~10.~~11. Age limits (Member age minimum, Member age maximum, gender restrictions);

~~11.~~12. Languages spoken by the Provider including American Sign Language;

~~12.~~13. Languages spoken by clinical staff;

14. Telehealth Provider indicators:

a. Only Telehealth;

b. No Telehealth (only in-person); or

c. Both Telehealth and in-person;

15. Telehealth site indicators:

a. Only Telehealth;

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b. No Telehealth (only in-person); or

c. Both Telehealth and in-person;

~~13.~~16. Practice address (including suite number);

~~14.~~17. City;

~~15.~~18. State;

~~16.~~19. Zip code;

~~17.~~20. Telephone number including area code;

~~18.~~21. Proximity to public transportation;

~~19.~~22. After-hours telephone number;

~~20.~~23. Office days and hours;

~~21.~~24. California license number and type of license;

~~22.~~25. Web site URL, if applicable;

~~23.~~26. Public email address, if available and attestation is obtained ~~(published no later than December 31, 2017); and;~~

~~24.~~27. Administrative email address;

~~25.~~28. Facility physical accessibility compliance (OSHA);

~~26.~~29. Provider type;

~~27.~~30. CalOptima program(s) (product/line of business);

~~28.~~31. Tier, if applicable;

~~29.~~32. Health Network affiliation;

~~30.~~33. Facility affiliations (hospital name);

~~31.~~34. Hospital admitting privileges;

~~32.~~35. An individual Provider's panel status is at least one (1) of the following:

a. Accepting new Members;

b. Accepting existing Members;

c. Available by referral only;

d. Available only through a hospital or Facility;

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e. Not accepting new patients; or

f. Accepting new and existing patients;

~~33.~~36. Special services, panel status, or certification such as California Children's Services (CCS) and/or Child Health and Disability Prevention (CHDP) and expiration; and

~~34.~~37. Supervising Physician full name and license number for mid-level ~~practitioners~~Providers , when applicable.

B. CalOptima's Provider and Web-based ~~directories~~Directories shall include:

1. All Providers who contract with a Health Network and CalOptima Community Network (CCN) to deliver health care services to Members including, but not limited to:

   a. Physicians and surgeons;

   b. Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service ~~providers~~Providers, nurse midwives, and dentists;

   c. Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHF), Rural Health Clinics (RHCs), and primary care clinics to the extent they are available in CalOptima service area;

   d. Health Home Program Providers;

   e. Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and

   f. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

2. Identification of Providers that are not available to all or new Members.

3. Instructions and information on how to use the ~~directory~~Directory. The instructions shall describe and explain any acronyms and symbols used within the ~~provider directory~~Provider Directory, information on how to use CalOptima services, and who to call for assistance.

   a. The ~~directory~~Directory shall be available in threshold languages, in accordance with CalOptima Policies CMC.4002: Cultural and Linguistic Services, DD.2002: Cultural and Linguistic Services, MA.4002: Cultural and Linguistic Services~~;~~.

4. A statement informing Members that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services.

5. Instructions on how to contact CalOptima if the ~~provider directory~~Provider Directory information appears to be inaccurate.

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6. Instructions on how to contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman if the ~~provider directory~~Provider Directory information appears to be inaccurate.

7. Instructions advising the Member to contact Customer Service to verify the availability of selected Providers.

8. A disclosure statement assuring Members of full and equal access to Covered Services, regardless of disability status.

9. A listing of the physical accessibility indicators with the accessibility symbol listed before the word "Accessibility" pursuant to DHCS guidance and CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. Health Networks ~~and,~~ CCN, Delegated Provider Groups, or a Provider (as applicable) shall ~~-~~submit to the Provider Data Management Services (PDMS) Department a written request to add, change, or terminate a Provider from the CalOptima Provider Directory or Web-based Directory as follows:~~.~~

1. Provider Additions: ~~a m~~Minimum of thirty (30) calendar days advanced written notice;

2. Provider Changes: ~~a m~~Minimum of thirty (30) calendar days advanced written notice; and

3. Provider Terminations: ~~a~~Minimum of ~~ninety~~ninety (90) calendar days advanced written notice in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services~~EE.1143: Medi-Cal Network Provider and Subcontractor Terminations Monitoring and Oversight~~.

~~C.~~D. On a semi-annual basis, a Health Network and CCN will require contracted Providers to confirm that their information in the Provider Directory is accurate and/or update the information, if applicable.

E. CalOptima shall maintain a process and system by which Providers may submit verification or changes to their listed information in the Provider Directory in a manner consistent with guidance from the DHCS and applicable contractual obligations.

~~CalOptima shall ensure the Web-based Provider Directory is made available in a machine-readable file and format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.~~

~~PROCEDURE~~

~~D.~~F. Health Network ~~and,~~ CCN~~-~~, Delegated Provider Group, or Provider Request to Add a Provider

1. ~~A **Health Network** and **CCN** shall request to add a **Provider** to the CalOptima Provider Directory and Web-based Directory by submitting the following to CalOptima's Provider Data Management Services (PDMS) Department including:~~
1. CalOptima's PDMS Department shall add a Health Network, Delegated Provider Group and/or CCN Provider to the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. CalOptima requires its Health Networks, subdelegates, Delegated Provider

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Groups, Providers and practitioners to promptly inform CalOptima of any changes to information regarding Provider demographics, credentialing, panel status, and other information requested on the CalOptima ACT form (Attachment A) or electronic notification (with applicable data) to ensure data accuracy, integrity and to audit/confirm the information provided by its Providers is true and correct.

2. A Health Network, CCN, Delegated Provider Group, or Provider add request shall include:

a. CalOptima (ACT) form (Attachment A) (recommended) ~~; recommended~~ or electronic notification with applicable data;

~~a. SCalOptima Add/Change/Term (ACT) form;~~

b. ~~A complete,~~ igned W9 form;

c. Health Network contract front and signature ~~or CCN/COD Contract Summary;~~page (if applicable);

d. Provider Profile: a complete Provider profile that includes the following information:

i. Legal, full name of the Provider, as shown on his or her medical license;

ii. Program information (contracted CalOptima programs) and effective date;

iii. Gender;

~~iii.~~iv. Primary, secondary, and tertiary specialty, as applicable;

~~iv.~~v. Board certified specialty, if applicable;

~~v.~~vi. Taxonomy~~;~~ (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

~~vi.~~vii. Area of focus, if applicable;

~~vii.~~viii. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

~~viii.~~ix. State license number;

~~i. Gender;~~

~~ix.~~x. Address, phone and facsimile number for the Provider service location;

~~x.~~xi. Days and hours of operation;

~~xi.~~xii. Hospital affiliation(s);

~~xii.~~xiii. Accepting new patients;

~~xiii.~~xiv. Accepting existing Members;

~~xiv.~~xv. Available by referral only;

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~~xv.~~xvi. Available only through a hospital or Facility; or

~~xvi.~~xvii. Not accepting new patients;

~~xvii.~~xviii. Accepting new and existing patients

~~xviii.~~xix. Age limits (member age minimum, member age maximum, gender restrictions~~;~~);

~~xix.~~xx. Languages spoken by the physician including American Sign Language;

~~xx.~~xxi. Languages spoken by clinical staff;

~~xxi.~~xxii. Telehealth Provider indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person;

xxiii. Telehealth site indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person;

~~xxii.~~xxiv. Medi-Cal enrolled (Y/N) and effective date;

~~xxiii.~~xxv. Medicare enrolled (Y/N); and

~~xxiv.~~xxvi. A copy of the "Provider Directory Listing Authorization" section of the physician profile for mid-level practitioners, when applicable.

e. For Facilities, a complete Facility profile~~,~~ that includes the following information:

i. Facility name;

ii. Location;

iii. Accreditation;

iv. Phone number;

v. NPI; ~~and~~

vi. Languages spoken at Facility~~.~~; and

vii. Telehealth indicator, site location.

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3. A Health ~~Networks and~~Network, CCN, Delegated Provider Group, or Provider shall submit a request to the PDMS Department by one (1) of the following methods:

   a. E-mail at ProviderOnline@caloptima.org; or

   b. Fax at 714-954-2330

4. If discrepancies are identified, the PDMS department shall reject and return the request to the requesting Health Networks ~~or CCN~~, CCN, Delegated Provider Group, or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

5. The PDMS Department shall update the Provider or Facility file(s) in the ~~provider~~Provider information system and, subsequently, the Web-based ~~directory~~Directory, within five (5) business days of receipt of completed information.

~~E.~~G. Health Network ~~and~~, CCN, Delegated Provider Group, or Provider Request to Change demographic or other information for a Provider, Practitioner or Facility

1. ~~A Health Network and CCN~~CalOptima's PDMS Department shall ~~request to change~~ update demographic or other ~~applicable~~ information ~~for a Provider or Facility~~ in the ~~CalOptima~~ system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory ~~by submitting changes to the following, including the CalOptima Add/Changes/Term (ACT) form, to the PDMS Department~~. A Health Network, CCN, Delegated Provider Group, or Provider change request shall include:

   a. Legal, full name of the practitioner, as shown on his or her medical license;

   b. Program information (contracted CalOptima programs) and effective date;

   c. Primary, secondary, and tertiary specialty, as applicable;

   d. Board certified specialty, if applicable;

   e. Taxonomy~~;~~ (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List~~);~~

   f. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

   g. Tax identification number (TIN);

   h. State license number;

   i. Gender;

   j. Address, telephone and facsimile number for the Provider service location, including a telephone number for after normal business hours, if applicable;

   k. Days and hours of operation;

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l. Hospital affiliation;

m. Accepting new patients;

n. Age limits (Member age minimum, Member age maximum, gender restrictions);

o. Languages spoken by the physician including American Sign Language;

p. Languages spoken by clinical staff;

q. Telehealth Provider indicators:

i. Only Telehealth;

ii. No Telehealth (only in-person); or

iii. Both telehealth and in-person;

r. Telehealth site indicators:

i. Only Telehealth;

ii. No Telehealth (only in-person); or

iii. Both telehealth and in-person;

~~q.~~s. Medi-Cal enrolled (Y/N) and effective date; and

~~r.~~t. Medicare enrolled (Y/N).

2. A Health Network ~~and,~~ CCN, Delegated Provider Group, or Provider shall submit requests for Provider changes to the PDMS Department by one (1) of the following methods:

a. E-mail at ProviderOnline@CalOptima.org; or

b. Fax at 714-954-2330

3. If discrepancies are identified, the PDMS department shall return the profile to the requesting Health Networks ~~and CCN~~, CCN, Delegated Provider Group or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

4. The PDMS Department shall update the Provider or Facility file(s) in the provider information system and the web-based directory within thirty (30) calendar days of receipt of completed information.

~~F.~~H. Health Network ~~and,~~ CCN, Delegated Provider Group, or Provider Request to Terminate a Provider or Facility:

1. ~~A Health Network or CCN~~CalOptima's PDMS Department shall ~~request to~~ terminate a Provider~~, practitioner,~~ or Facility ~~from~~in the system of record within five (5) business days of

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submission based on the termination date indicated on the CalOptima ACT form (Attachment A) or electronic notification (with applicable data) for inclusion for inclusion in the Provider Directory and Web-based Directory ~~by submitting the following, including the CalOptima Add/Change/Term (ACT) form, to the PDMS Department~~. A Health Network, CCN, Delegated Provider Group, or Provider termination request shall include:

a. A copy of the Provider or Facility termination notice with the effective date for termination.

2. ~~If a~~For terminating ~~Practitioner is a **Primary Care Provider (PCP),**~~Providers, CalOptima or the Health Network shall notify affected Members and DHCS, as applicable, in accordance with CalOptima Policies DD.2008: Health Network Selection Process~~;~~, DD.2012: Member Notification of Change in the Availability or Location of Covered Services~~;~~, MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services. The PDMS Department shall notify Customer Service of ~~PCP~~ Provider termination for purpose of Member notification and re-assignment of Members.

~~G.~~I. On a weekly basis, the PDMS Department shall send to the Health Networks and CCN Provider, Practitioner and Facility reports of Additions, Changes, and Terminations for review of accuracy.

1. If discrepancies are identified on any Provider files, Health Networks and CCN shall address the discrepancies.

a. Upon addressing discrepancies, the Health Network or CCN shall notify the PDMS Department.

b. The PDMS Department shall update the Provider, practitioner and Facility files within five (5) business days in the provider information system and shall update the Web-based Directory.

~~H.~~J. On a monthly basis, CalOptima shall obtain an electronic update from the National Committee on Quality Assurance (NCQA) regarding providers who achieve Patient-Centered Medical Home (PCMH) recognition status. The updates from NCQA shall be seen on the Web-based Directory within ten (10) calendar days after receipt of the data file from NCQA.

~~I.~~K. Verification of Provider Information

1. CalOptima and Health Networks shall verify and update all information outlined in Section ~~II.C~~III.A. of this ~~policy~~Policy to ensure accuracy of the information listed in the Provider Directory and Web-based Directory. CalOptima and Health Networks shall notify contracted Providers of the requirement to maintain and attest to the accuracy of Provider Directory information.

a. Notification

i. On a semi-annual basis, CalOptima shall notify and instruct Providers of the process to verify or update information listed in the Provider Directory and Web-based Directory, in a manner consistent with guidance from DHCS and applicable contractual obligations.

b. Verification

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i. On a semi-annual basis, CalOptima shall distribute a Provider Data Universe to Health Networks and CCN in the first (1st) and third (3rd) quarter of each calendar year.

ii. Health Networks and CCN shall conduct validation of all information listed in the Provider Data Universe in accordance with this ~~policy~~Policy.

iii. Health Networks and CCN shall document the outcome of each attempt to verify ~~provider~~Provider information.

iv. If through this process, a Health ~~Networks and~~Network or CCN discovers a Provider has retired, ceased practicing, or if the Provider is no longer affiliated with a practice, CalOptima shall remove the Provider from the Provider Directory in accordance with Section III.~~C~~H. of this ~~policy~~Policy.

c. Provider Directory Validation Attestation

i. Health Networks and CCN shall require contracted Providers to validate and attest in writing to the accuracy of their Provider Directory information.

ii. If a Provider fails to respond to the request for validation and written attestation within thirty (30) business days, Health Networks and CCN shall attempt to verify if the Provider information is accurate or requires updating within fifteen (15) business days.

iii. If a Health Networks ~~and~~ or CCN is unable to verify whether the Provider's information is accurate or requires updating, a notice shall be sent to the Provider informing them of the intent to remove them from the Provider Directory for failure to submit appropriate validation and written attestation in accordance with this ~~policy~~Policy.

a) Health Networks and CCN shall notify Providers ten (10) business days prior to removal from the Provider Directory.

i) Providers that fail to respond will be removed from the Provider Directory in accordance with Section III.~~C~~H. of this ~~policy~~Policy.

ii) Providers will not be removed from the Provider Directory if a response is received before the end of the tenth (10th) business day.

iv. A Provider's failure to validate and attest to the accuracy of their Provider Directory data may result in panel closure, suppression from the Provider Directory, and/or delay of payment.

v. General acute care hospitals shall not be required to provide a response.

d. Collection and Submission of Provider Attestation

i. Health Networks and CCN shall collect written ~~provider~~Provider attestations from all contracted Providers for annual submission to ~~CalOptima's~~the CalOptima Audit and Oversight Department.

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ii. Health Networks and CCN shall submit written Provider attestations, as requested by CalOptima's Audit and Oversight department, in the fourth (4th) quarter of each calendar year.

iii. Written Provider attestations must be stored electronically for a minimum of ten (10) years.

~~J.~~L. Access to CalOptima Provider Directory and Web-based Directory

1. CalOptima shall provide Members, prospective Members, Providers and members of the public information from the CalOptima Provider Directory and Web-based Directory in alternate media formats. Alternate media formats include:

   a. Print

      i. CalOptima staff shall send by U.S. Postal Service mail to new Members the CalOptima Provider Directory upon enrollment in the CalOptima program or by request, postmarked no later than five (5) business days following the date of the request and in accordance with CalOptima Policy DD.2008: Health Network Selection Process; or

   b. Telephone

      i. CalOptima staff shall utilize the Web-based Directory to assist Members over the phone in finding a Provider. If a Member requests Provider information or the CalOptima Provider Directory, CalOptima staff shall print and send the requested information to the Member by U.S. mail.

~~K.~~M. CalOptima shall review its Web-based Directory for usability every three (3) years. Review shall include, but is not limited to:

1. Font size;
2. Reading level;
3. Ease of navigation;
4. Intuitive content organization; and
5. Directories in different languages.

~~L.~~N. Validation of Web-based Directory

1. A Health ~~**Networks**~~Network and CCN shall validate the Web-based Directory Provider, Practitioner and Facility information at least annually. Validation shall consist of the following:

   a. Data sources, and

   b. Limitations for each item of information on the Web-based Directory.

2. Web-based Directory Provider, Practitioner and Facility validation and frequency table:

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	Provider Definition	Information Collection and Validation
Name	The alternative name preferred by and as specified by the practitioner, provider, or Facility which may be familiar to patients and can be published on provider directory.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Type	Includes: Physicians and surgeons; Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists; Federally Qualified Health Centers (FQHCs) or primary care clinics; Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
License Number	California license number of the practitioner. Catenate the license type letter (NP, CNM, and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
NPI	National provider identifier of the practitioner (NPI type 1, 10 digits)	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
	National provider identifier of the hospital (NPI type 2, 10 digits)	
Gender	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Address	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice City	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice State	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Zip Code	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between the validation time frames.
After Hours Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Age Limits	Member age minimum, member age maximum and gender restriction.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Specialty	The clinical area in which the CalOptima contracted physician received specialized training, such as a residency or fellowship.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Taxonomy (primary, secondary, tertiary)	The taxonomy code of the specialty for which the practitioner has. ~~NUCC Taxonomy Code List: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53)~~	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
~~National Uniform Claim Committee (NUCC)~~	~~The official maintainer of the Health Care Provider Taxonomy code set.~~	~~Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.~~
Area of Focus	The specific focus of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Hospital Affiliations (Hospital Name)	The name of CalOptima contracted hospital where the practitioner him/herself is on	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames

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	Provider Definition	Information Collection and Validation
	staff and/or having admitting privilege.	
Hospital Admitting Privileges	Includes: Active, Provisional, Courtesy, Surgical, Consultant, Suspended, Limited, Associate Staff, Honorary Staff, and Senior Attending.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Board Certification	When a health care practitioner is board certified, it means that he or she has applied for and been awarded certification from the American Board of Medical Specialties (ABMS), American Osteopathic Association, or other recognized board. Board certification is a voluntary process. To become board certified, a physician must: • Graduate from an accredited professional school • Complete a specific type and length of training in a specialty • Practice for a specified amount of time in that specialty • Pass an examination given by the professional specialty board For more information about your physician's board certification, visit the ABMS website at www.abms.org	Information is self-reported and updated every three (3) years during re-credentialing. Changes may occur between validation time frames.
Acceptance of New Patients	Indicates whether the provider is accepting new patients, accepting existing patients, accepting new and existing patients, accepting through referral only, accepting through a hospital or Facility, not accepting new patients.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Language or Languages including American Sign Language	The languages other than English that the provider speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Clinical Staff Languages	The languages other than English that the clinical staff speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
Telehealth Provider indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Provider indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Telehealth site indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Site indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Physical Accessibility Compliance	Refers to a site, Facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability.	Upon completion of a provider Facility site review, by using the data obtained through Attachment C of the FSR tool to determine and identify physical accessibility indicators.
Medical Group Affiliations	A group of contracted physicians that provides health care services to CalOptima Members.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Health Network Affiliations	A group of doctors and hospitals that provides health care services and has a contract with CalOptima.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
CalOptima Program (product)	The line of business the provider and/or Facility participates in	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Special Services	Services that the provider is certified in such as CCS and CHDP.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Administrative Email Address	For office contact only.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Web URL Address	If applicable.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Public Email Addresses	Public email address (if applicable and attestation is completed) for patient communications.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Office Days and Hours	Days and times the provider and/or Facility is open for business.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Supervising Physician Full Name and License Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
for Mid-level Practitioners		

3. CalOptima's Quality Improvement Department shall validate the Web-based Directory Hospital information every three (3) years. Validation shall consist of the following:

   a. Data sources; and

   b. Limitations for each item of information on the Web-based Directory.

4. Web-based Directory Facility validation and frequency table:

	Facility Definition	Information Collection and Validation
Facility	General acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Facility Name	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Location	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Accreditation	Identifies whether the Facility undergoes a review to assess the quality of its systems and processes by an external accreditation organization.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Hospital Quality Data from Recognized Sources	~~N/A~~	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.

~~**III.**~~

IV. ATTACHMENT(S)

A. CalOptima ~~Health Network Affiliation Addition,~~ Add/Change~~, and Termination Form~~/Term (ACT) form
B. ACT Form User Guide
C. National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy Code Set

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~~V.~~

~~VI.~~V. REFERENCE(S)

A. CalOptima Contract for Health Provider Care Services
B. CalOptima Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicaid & Medicare Services (CMS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Policy CMC.4002: Cultural and Linguistic Services
G. CalOptima Policy CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification
H. CalOptima Policy DD.2002: Cultural and Linguistic Services
I. CalOptima Policy DD.2008: Health Network Selection Process
J. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
~~J. CalOptima Policy EE.1143: Medi-Cal Network Provider and Subcontractor Terminations Monitoring and Oversight~~
K. CalOptima Policy GG.1608Δ: Full Scope Site ~~Review~~Reviews
L. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
M. CalOptima Policy MA.4002: Cultural and Linguistic Services
N. CalOptima Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
O. Health and Safety Code (HSC), § 1367.27
P. Medi-Cal Managed Care Division (MMCD) Policy Letter 00-~~02~~002, Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
Q. Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009, Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
R. Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations
~~R.~~S. Title 42, Code of Federal Regulations (CFR), § 438.10(h)
T. NUCC Taxonomy Code List: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53~~https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53~~

~~VII.~~

~~VIII.~~VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/17/2014	Department of Health Care Services	Approved As Submitted
01/26/2015	Department of Health Care Services	Approved As Submitted
07/06/2015	Department of Health Care Services	Approved As Submitted
07/26/2021	Department of Health Care Services	Approved As Submitted

~~IX.~~

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~~X.~~VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

~~XI.~~

~~XII.~~VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/15/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2017	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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~~XIII.~~IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks ~~shall~~ are recommended to submit ACT forms and ~~required~~ necessary documentation ~~required~~ as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, C alifornia Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks ~~shall~~ are recommended to submit ACT forms and ~~required~~ necessary documentation ~~required~~ as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Delegated Provider Group	Health care entity with authority to credential its health care practitioners.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Health Homes Program (HHP) Provider	A physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State to be qualified to be a health home for eligible Members with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic: 1. Has the systems and infrastructure in place to provide HHP Services; and 2. Satisfies the qualification standards established by DHCS and CalOptima.

For 2022025 BOD Review Only

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMG),~~ physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
National Uniform Claim Committee (NUCC)	The official maintainer of the Health Care Provider Taxonomy code set. https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53~~https://taxonomy.nucc.org/~~
Primary Care Provider (PCP)	A physician who focuses his or her practice of medicine to general practice or who is a board verified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under CalOptima program.
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so,
~~Provider~~Telehealth	~~All contracted Providers including physicians, ancillary providers, and Facilities.~~The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.
Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.

For 2022020 Review Only

Policy:	EE.1101Δ
Title:	**Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory**
Department:	Network Operations
Section:	Provider Relations
Interim CEO Approval:	
Effective Date:	11/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 2/20/2023 BOD Review Only

I. PURPOSE

This policy outlines the process for adding, changing, or terminating a Provider in the CalOptima Provider Directory and Web-based Directory.

II. POLICY

A. For each CalOptima program, CalOptima shall publish a printed hardcopy and online PDF version of the Provider Directory on a monthly basis, and a Web-based Directory that is updated within forty-eight (48) hours of an Addition, Change, or Termination of a Provider.

B. The Provider Directory shall include information on Health Networks, hospitals, Primary Care Providers (PCPs), OB/GYNs, specialists, behavioral health Providers, managed long-term services and support (MLTSS) Providers, urgent care centers, ancillary Providers, Facilities, and pharmacies who are credentialed and contracted with CalOptima directly or through a subcontracted agreement with a Health Network.

C. CalOptima shall ensure the printed hardcopy and online PDF version of the Provider Directory address Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) requirements for Provider Directories.

D. CalOptima shall submit the Medi-Cal Provider Directory to DHCS every six (6) months and shall include a PDF with the submission which DHCS can use for distribution, as needed.

E. CalOptima and Health Networks shall report changes to information for a Provider or Facility in the CalOptima Provider Directory and Web-based Directory on an ongoing basis in accordance with this Policy.

F. CalOptima, Health Networks, Delegated Provider Groups, and Providers shall validate their directory information on a semi-annual basis in accordance with this Policy.

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G. CalOptima shall ensure the Web-based Provider Directory is made available in a machine-readable file and format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.

III. PROCEDURE

A. CalOptima shall publish a Provider Directory for each CalOptima program and a Web-based Directory that includes, but is not limited to, the following information to help existing and prospective Members choose physicians:

1. Headers to indicate city or region names (in alphabetical order);
2. Name;
3. Gender;
4. Specialty;
5. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);
6. Area of focus, if applicable;
7. National Provider Identifier (NPI);
8. Hospital affiliation(s);
9. Primary care clinic or Medical Group affiliations, if applicable;
10. Board certification, if applicable;
11. Age limits (Member age minimum, Member age maximum, gender restrictions);
12. Languages spoken by the Provider including American Sign Language;
13. Languages spoken by clinical staff;
14. Telehealth Provider indicators:
    a. Only Telehealth;
    b. No Telehealth (only in-person); or
    c. Both Telehealth and in-person;
15. Telehealth site indicators:
    a. Only Telehealth;

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b. No Telehealth (only in-person); or

c. Both Telehealth and in-person;

16. Practice address (including suite number);

17. City;

18. State;

19. Zip code;

20. Telephone number including area code;

21. Proximity to public transportation;

22. After-hours telephone number;

23. Office days and hours;

24. California license number and type of license;

25. Web site URL, if applicable;

26. Public email address, if available and attestation is obtained;

27. Administrative email address;

28. Facility physical accessibility compliance (OSHA);

29. Provider type;

30. CalOptima program(s) (product/line of business);

31. Tier, if applicable;

32. Health Network affiliation;

33. Facility affiliations (hospital name);

34. Hospital admitting privileges;

35. An individual Provider's panel status is at least one (1) of the following:

a. Accepting new Members;

b. Accepting existing Members;

c. Available by referral only;

d. Available only through a hospital or Facility;

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e. Not accepting new patients; or

f. Accepting new and existing patients;

36. Special services, panel status, or certification such as California Children's Services (CCS) and/or Child Health and Disability Prevention (CHDP) and expiration; and

37. Supervising Physician full name and license number for mid-level Providers , when applicable.

B. CalOptima's Provider and Web-based Directories shall include:

1. All Providers who contract with a Health Network and CalOptima Community Network (CCN) to deliver health care services to Members including, but not limited to:

a. Physicians and surgeons;

b. Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service Providers, nurse midwives, and dentists;

c. Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHF), Rural Health Clinics (RHCs), and primary care clinics to the extent they are available in CalOptima service area;

d. Health Home Program Providers;

e. Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and

f. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

2. Identification of Providers that are not available to all or new Members.

3. Instructions and information on how to use the Directory. The instructions shall describe and explain any acronyms and symbols used within the Provider Directory, information on how to use CalOptima services, and who to call for assistance.

a. The Directory shall be available in threshold languages, in accordance with CalOptima Policies CMC.4002: Cultural and Linguistic Services, DD.2002: Cultural and Linguistic Services, MA.4002: Cultural and Linguistic Services.

4. A statement informing Members that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services.

5. Instructions on how to contact CalOptima if the Provider Directory information appears to be inaccurate.

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6. Instructions on how to contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman if the Provider Directory information appears to be inaccurate.

7. Instructions advising the Member to contact Customer Service to verify the availability of selected Providers.

8. A disclosure statement assuring Members of full and equal access to Covered Services, regardless of disability status.

9. A listing of the physical accessibility indicators with the accessibility symbol listed before the word "Accessibility" pursuant to DHCS guidance and CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. Health Networks, CCN, Delegated Provider Groups, or a Provider (as applicable) shall submit to the Provider Data Management Services (PDMS) Department a written request to add, change, or terminate a Provider from the CalOptima Provider Directory or Web-based Directory as follows:

1. Provider Additions: Minimum of thirty (30) calendar days advanced written notice;

2. Provider Changes: Minimum of thirty (30) calendar days advanced written notice; and

3. Provider Terminations: Minimum of ninety (90) calendar days advanced written notice in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

D. On a semi-annual basis, a Health Network and CCN will require contracted Providers to confirm that their information in the Provider Directory is accurate and/or update the information, if applicable.

E. CalOptima shall maintain a process and system by which Providers may submit verification or changes to their listed information in the Provider Directory in a manner consistent with guidance from the DHCS and applicable contractual obligations.

F. Health Network, CCN, Delegated Provider Group, or Provider Request to Add a Provider

1. CalOptima's PDMS Department shall add a Health Network, Delegated Provider Group and/or CCN Provider to the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. CalOptima requires its Health Networks, subdelegates, Delegated Provider Groups, Providers and practitioners to promptly inform CalOptima of any changes to information regarding Provider demographics, credentialing, panel status, and other information requested on the CalOptima ACT form (Attachment A) or electronic notification (with applicable data) to ensure data accuracy, integrity and to audit/confirm the information provided by its Providers is true and correct.

2. A Health Network, CCN, Delegated Provider Group, or Provider add request shall include:

a. CalOptima (ACT) form (Attachment A) (recommended) or electronic notification with applicable data;

b. Signed W9 form;

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c. Health Network contract front and signature page (if applicable);

d. Provider Profile: a complete Provider profile that includes the following information:

i. Legal, full name of the Provider, as shown on his or her medical license;

ii. Program information (contracted CalOptima programs) and effective date;

iii. Gender;

iv. Primary, secondary, and tertiary specialty, as applicable;

v. Board certified specialty, if applicable;

vi. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

vii. Area of focus, if applicable;

viii. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

ix. State license number;

x. Address, phone and facsimile number for the Provider service location;

xi. Days and hours of operation;

xii. Hospital affiliation(s);

xiii. Accepting new patients;

xiv. Accepting existing Members;

xv. Available by referral only;

xvi. Available only through a hospital or Facility; or

xvii. Not accepting new patients;

xviii. Accepting new and existing patients

xix. Age limits (member age minimum, member age maximum, gender restrictions);

xx. Languages spoken by the physician including American Sign Language;

xxi. Languages spoken by clinical staff;

xxii. Telehealth Provider indicators:

a) Only Telehealth;

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b) No Telehealth (only in-person); or

c) Both telehealth and in-person;

xxiii. Telehealth site indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person;

xxiv. Medi-Cal enrolled (Y/N) and effective date;

xxv. Medicare enrolled (Y/N); and

xxvi. A copy of the "Provider Directory Listing Authorization" section of the physician profile for mid-level practitioners, when applicable.

e. For Facilities, a complete Facility profile that includes the following information:

i. Facility name;

ii. Location;

iii. Accreditation;

iv. Phone number;

v. NPI;

vi. Languages spoken at Facility; and

vii. Telehealth indicator, site location.

3. A Health Network, CCN, Delegated Provider Group, or Provider shall submit a request to the PDMS Department by one (1) of the following methods:

a. E-mail at ProviderOnline@caloptima.org; or

b. Fax at 714-954-2330

4. If discrepancies are identified, the PDMS department shall reject and return the request to the requesting Health Networks, CCN, Delegated Provider Group, or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

5. The PDMS Department shall update the Provider or Facility file(s) in the Provider information system and, subsequently, the Web-based Directory, within five (5) business days of receipt of completed information.

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G. Health Network, CCN, Delegated Provider Group, or Provider Request to Change demographic or other information for a Provider, Practitioner or Facility

1. CalOptima's PDMS Department shall update demographic or other information in the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. A Health Network, CCN, Delegated Provider Group, or Provider change request shall include:

   a. Legal, full name of the practitioner, as shown on his or her medical license;

   b. Program information (contracted CalOptima programs) and effective date;

   c. Primary, secondary, and tertiary specialty, as applicable;

   d. Board certified specialty, if applicable;

   e. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

   f. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

   g. Tax identification number (TIN);

   h. State license number;

   i. Gender;

   j. Address, telephone and facsimile number for the Provider service location, including a telephone number for after normal business hours, if applicable;

   k. Days and hours of operation;

   l. Hospital affiliation;

   m. Accepting new patients;

   n. Age limits (Member age minimum, Member age maximum, gender restrictions);

   o. Languages spoken by the physician including American Sign Language;

   p. Languages spoken by clinical staff;

   q. Telehealth Provider indicators:

      i. Only Telehealth;

      ii. No Telehealth (only in-person); or

      iii. Both telehealth and in-person;

   r. Telehealth site indicators:

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i. Only Telehealth;

ii. No Telehealth (only in-person); or

iii. Both telehealth and in-person;

s. Medi-Cal enrolled (Y/N) and effective date; and

t. Medicare enrolled (Y/N).

2. A Health Network, CCN, Delegated Provider Group, or Provider shall submit requests for Provider changes to the PDMS Department by one (1) of the following methods:

a. E-mail at ProviderOnline@CalOptima.org; or

b. Fax at 714-954-2330

3. If discrepancies are identified, the PDMS department shall return the profile to the requesting Health Networks, CCN, Delegated Provider Group or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

4. The PDMS Department shall update the Provider or Facility file(s) in the provider information system and the web-based directory within thirty (30) calendar days of receipt of completed information.

H. Health Network, CCN, Delegated Provider Group, or Provider Request to Terminate a Provider or Facility:

1. CalOptima's PDMS Department shall terminate a Provider or Facility in the system of record within five (5) business days of submission based on the termination date indicated on the CalOptima ACT form (Attachment A) or electronic notification (with applicable data) for inclusion for inclusion in the Provider Directory and Web-based Directory. A Health Network, CCN, Delegated Provider Group, or Provider termination request shall include:

a. A copy of the Provider or Facility termination notice with the effective date for termination.

2. For terminating Providers, CalOptima or the Health Network shall notify affected Members and DHCS, as applicable, in accordance with CalOptima Policies DD.2008: Health Network Selection Process, DD.2012: Member Notification of Change in the Availability or Location of Covered Services, MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services. The PDMS Department shall notify Customer Service of Provider termination for purpose of Member notification and re-assignment of Members.

I. On a weekly basis, the PDMS Department shall send to the Health Networks and CCN Provider, Practitioner and Facility reports of Additions, Changes, and Terminations for review of accuracy.

1. If discrepancies are identified on any Provider files, Health Networks and CCN shall address the discrepancies.

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a. Upon addressing discrepancies, the Health Network or CCN shall notify the PDMS Department.

b. The PDMS Department shall update the Provider, practitioner and Facility files within five (5) business days in the provider information system and shall update the Web-based Directory.

J. On a monthly basis, CalOptima shall obtain an electronic update from the National Committee on Quality Assurance (NCQA) regarding providers who achieve Patient-Centered Medical Home (PCMH) recognition status. The updates from NCQA shall be seen on the Web-based Directory within ten (10) calendar days after receipt of the data file from NCQA.

K. Verification of Provider Information

1. CalOptima and Health Networks shall verify and update all information outlined in Section III.A. of this Policy to ensure accuracy of the information listed in the Provider Directory and Web-based Directory. CalOptima and Health Networks shall notify contracted Providers of the requirement to maintain and attest to the accuracy of Provider Directory information.

a. Notification

i. On a semi-annual basis, CalOptima shall notify and instruct Providers of the process to verify or update information listed in the Provider Directory and Web-based Directory, in a manner consistent with guidance from DHCS and applicable contractual obligations.

b. Verification

i. On a semi-annual basis, CalOptima shall distribute a Provider Data Universe to Health Networks and CCN in the first (1st) and third (3rd) quarter of each calendar year.

ii. Health Networks and CCN shall conduct validation of all information listed in the Provider Data Universe in accordance with this Policy.

iii. Health Networks and CCN shall document the outcome of each attempt to verify Provider information.

iv. If through this process, a Health Network or CCN discovers a Provider has retired, ceased practicing, or if the Provider is no longer affiliated with a practice, CalOptima shall remove the Provider from the Provider Directory in accordance with Section III.H. of this Policy.

c. Provider Directory Validation Attestation

i. Health Networks and CCN shall require contracted Providers to validate and attest in writing to the accuracy of their Provider Directory information.

ii. If a Provider fails to respond to the request for validation and written attestation within thirty (30) business days, Health Networks and CCN shall attempt to verify if the Provider information is accurate or requires updating within fifteen (15) business days.

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iii. If a Health Networks or CCN is unable to verify whether the Provider's information is accurate or requires updating, a notice shall be sent to the Provider informing them of the intent to remove them from the Provider Directory for failure to submit appropriate validation and written attestation in accordance with this Policy.

a) Health Networks and CCN shall notify Providers ten (10) business days prior to removal from the Provider Directory.

i) Providers that fail to respond will be removed from the Provider Directory in accordance with Section III.H. of this Policy.

ii) Providers will not be removed from the Provider Directory if a response is received before the end of the tenth (10th) business day.

iv. A Provider's failure to validate and attest to the accuracy of their Provider Directory data may result in panel closure, suppression from the Provider Directory, and/or delay of payment.

v. General acute care hospitals shall not be required to provide a response.

d. Collection and Submission of Provider Attestation

i. Health Networks and CCN shall collect written Provider attestations from all contracted Providers for annual submission to the CalOptima Audit and Oversight Department.

ii. Health Networks and CCN shall submit written Provider attestations, as requested by CalOptima's Audit and Oversight department, in the fourth (4th) quarter of each calendar year.

iii. Written Provider attestations must be stored electronically for a minimum of ten (10) years.

L. Access to CalOptima Provider Directory and Web-based Directory

1. CalOptima shall provide Members, prospective Members, Providers and members of the public information from the CalOptima Provider Directory and Web-based Directory in alternate media formats. Alternate media formats include:

a. Print

i. CalOptima staff shall send by U.S. Postal Service mail to new Members the CalOptima Provider Directory upon enrollment in the CalOptima program or by request, postmarked no later than five (5) business days following the date of the request and in accordance with CalOptima Policy DD.2008: Health Network Selection Process; or

b. Telephone

i. CalOptima staff shall utilize the Web-based Directory to assist Members over the phone in finding a Provider. If a Member requests Provider information or the CalOptima Provider Directory, CalOptima staff shall print and send the requested information to the Member by U.S. mail.

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M. CalOptima shall review its Web-based Directory for usability every three (3) years. Review shall include, but is not limited to:

1. Font size;

2. Reading level;

3. Ease of navigation;

4. Intuitive content organization; and

5. Directories in different languages.

N. Validation of Web-based Directory

1. A Health Network and CCN shall validate the Web-based Directory Provider, Practitioner and Facility information at least annually. Validation shall consist of the following:

   a. Data sources, and

   b. Limitations for each item of information on the Web-based Directory.

2. Web-based Directory Provider, Practitioner and Facility validation and frequency table:

	Provider Definition	**Information Collection and Validation**
Name	The alternative name preferred by and as specified by the practitioner, provider, or Facility which may be familiar to patients and can be published on provider directory.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Type	Includes: Physicians and surgeons; Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists; Federally Qualified Health Centers (FQHCs) or primary care clinics; Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics,	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
	ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.	
License Number	California license number of the practitioner. Catenate the license type letter (NP, CNM, and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
NPI	National provider identifier of the practitioner (NPI type 1, 10 digits) National provider identifier of the hospital (NPI type 2, 10 digits)	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Gender	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Address	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice City	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice State	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Zip Code	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between the validation time frames.
After Hours Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Age Limits	Member age minimum, member age maximum and gender restriction.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
Specialty	The clinical area in which the CalOptima contracted physician received specialized training, such as a residency or fellowship.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Taxonomy (primary, secondary, tertiary)	The taxonomy code of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Area of Focus	The specific focus of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Hospital Affiliations (Hospital Name)	The name of CalOptima contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames
Hospital Admitting Privileges	Includes: Active, Provisional, Courtesy, Surgical, Consultant, Suspended, Limited, Associate Staff, Honorary Staff, and Senior Attending.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Board Certification	When a health care practitioner is board certified, it means that he or she has applied for and been awarded certification from the American Board of Medical Specialties (ABMS), American Osteopathic Association, or other recognized board. Board certification is a voluntary process. To become board certified, a physician must: • Graduate from an accredited professional school • Complete a specific type and length of training in a specialty • Practice for a specified amount of time in that specialty • Pass an examination given by the professional specialty board For more information about your physician's board certification, visit the ABMS website at www.abms.org	Information is self-reported and updated every three (3) years during re-credentialing. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
Acceptance of New Patients	Indicates whether the provider is accepting new patients, accepting existing patients, accepting new and existing patients, accepting through referral only, accepting through a hospital or Facility, not accepting new patients.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Language or Languages including American Sign Language	The languages other than English that the provider speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Clinical Staff Languages	The languages other than English that the clinical staff speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Telehealth Provider indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Provider indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Telehealth site indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Site indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Physical Accessibility Compliance	Refers to a site, Facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability.	Upon completion of a provider Facility site review, by using the data obtained through Attachment C of the FSR tool to determine and identify physical accessibility indicators.
Medical Group Affiliations	A group of contracted physicians that provides health care services to CalOptima Members.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Health Network Affiliations	A group of doctors and hospitals that provides health care services and has a contract with CalOptima.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
CalOptima Program (product)	The line of business the provider and/or Facility participates in	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Special Services	Services that the provider is certified in such as CCS and CHDP.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

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	Provider Definition	Information Collection and Validation
Administrative Email Address	For office contact only.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Web URL Address	If applicable.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Public Email Addresses	Public email address (if applicable and attestation is completed) for patient communications.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Office Days and Hours	Days and times the provider and/or Facility is open for business.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Supervising Physician Full Name and License Number for Mid-level Practitioners	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

3. CalOptima's Quality Improvement Department shall validate the Web-based Directory Hospital information every three (3) years. Validation shall consist of the following:

   a. Data sources; and

   b. Limitations for each item of information on the Web-based Directory.

4. Web-based Directory Facility validation and frequency table:

	Facility Definition	Information Collection and Validation
Facility	General acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Facility Name	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Location	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Accreditation	Identifies whether the Facility undergoes a review to assess the quality of its systems and processes by an external accreditation organization.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.

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Hospital Quality Data from Recognized Sources	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.

IV. ATTACHMENT(S)

A. CalOptima Add/Change/Term (ACT) form
B. ACT Form User Guide
C. National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy Code Set

V. REFERENCE(S)

A. CalOptima Contract for Health Provider Care Services
B. CalOptima Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicaid & Medicare Services (CMS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Policy CMC.4002: Cultural and Linguistic Services
G. CalOptima Policy CMC.4010: Health Network and Primary Care Provider Selection, Assignment and Notification
H. CalOptima Policy DD.2002: Cultural and Linguistic Services
I. CalOptima Policy DD.2008: Health Network Selection Process
J. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
K. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
L. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
M. CalOptima Policy MA.4002: Cultural and Linguistic Services
N. CalOptima Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
O. Health and Safety Code (HSC), § 1367.27
P. Medi-Cal Managed Care Division (MMCD) Policy Letter 00-002, Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
Q. Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009, Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
R. Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations
S. Title 42, Code of Federal Regulations (CFR), § 438.10(h)
T. NUCC Taxonomy Code List: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/17/2014	Department of Health Care Services	Approved As Submitted
01/26/2015	Department of Health Care Services	Approved As Submitted
07/06/2015	Department of Health Care Services	Approved As Submitted

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07/26/2021	Department of Health Care Services	Approved As Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/15/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2015	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2017	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	EE.1101Δ	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, C alifornia Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Delegated Provider Group	Health care entity with authority to credential its health care practitioners.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Health Homes Program (HHP) Provider	A physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State to be qualified to be a health home for eligible Members with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic: 1. Has the systems and infrastructure in place to provide HHP Services; and 2. Satisfies the qualification standards established by DHCS and CalOptima.

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Term	Definition
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 to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima program.
National Uniform Claim Committee (NUCC)	The official maintainer of the Health Care Provider Taxonomy code set. https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
Primary Care Provider (PCP)	A physician who focuses his or her practice of medicine to general practice or who is a board verified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under CalOptima program.
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so,
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.
Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.

1
2

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Add, Change ~~,~~ and Termination Form

~~This form~~It ~~must be completed~~is recommended that this form ~~to report~~be used to report any additions, changes, and/or terminations to a provider's network affiliates.

~~A separate form must be completed for each contracted provider terminated or whose status is being changed~~If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

~~Line of Business~~Program (Check all that apply)	☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME		PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE / ZIP
REMIT ADDRESS		CITY	STATE / ZIP
OFFICE MANAGER	PHONE ~~NUMBER~~	FAX ~~NUMBER~~	PUBLIC E-MAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CHDP ☐ CPSP	

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVLEGES		
1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION ~~REQUIRED~~ REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION	~~REQUIREMENTS~~REQUIREMENTS: The Provider Relations (PR)~~R~~ Representative (Rep) ~~must~~ must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR Rep.		
	Effective Date **(required)**:	Date Credentialing Completed (within the last 3 years)	Current Facility Site Review Date (within last 3 years)
	PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH**	☐ **Open Panel /** ☐ **Closed Panel**
		☐ **PCP**	☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients
		☐ **SPECIALIST**	
☐ CHANGE IN PANEL STATUS	PROVIDER TYPE (If applicable, check both)	**REQUIREMENTS:** Panel changes are effective the date of processing.	
		☐ **PCP**	☐ **Open Panel /** ☐ **Closed Panel**
		☐ **SPECIALIST**	☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients
☐	~~REQUIREMENTS:~~REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.		

TAX I.D. CHANGE	Effective Date of New Tax I.D. (required):	Previous Tax I.D.	New Tax I.D.

ACTION ~~REQUIRED~~REQUIREMENTS cont. (Check all that apply)

TERMINATION

~~REQUIREMENTS:~~REQUIREMENTS: ~~-~~Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. ~~-~~If a copy is not attached, the form will be rejected by PDMS and returned to the PR Rep.
~~returned to the PR Rep~~

Effective Date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider r~~R~~etired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider d~~D~~eceased
- ☐ Provider unwilling to accept member / payment terms
- ☐ Termed due to review action

PCP Termination: ~~-~~Assign member to new PCP: ~~-~~ _____
Name of new PCP

Number of Members Impacted (As of Date Received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____ ☐ **OneCare Connect** _____

Date Member Notice was mailed (if Member Notice has not been sent, please put anticipated date and notify CalOptima if date changes):

Number of days' notice provider gave to MCP:

ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

~~REQUIREMENTS:~~REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address, and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. ~~-~~If PCP site, a Facility Site Review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. ~~–~~Note: The form contains three (3) address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-P~~p~~erson	
Address		City	State / ZIP~~ip~~
Phone ~~Number~~	Fax ~~Number~~	Office Hours	After ~~-~~Hours Phone ~~Number~~
Office Manager		E-mail Address	

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
Address		City	State / Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number
Office Manager		E-mail Address	

LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages Spoken by Provider

1. _____ 2. _____ 3. _____

OTHER

Comments:

~~I certify that the above information is true, accurate and complete to the best of my knowledge and that I am authorized to execute this document on behalf of the applicant. I understand that incorrect or inaccurate information may affect the applicant's eligibility to receive CalOptima reimbursement and that the applicant must report changes in the above information to the CalOptima Provider Enrollment Unit. I hereby further declare that the applicant listed above and its agents (a) have not been convicted of a criminal offense related to health care in the past seven (7) years; and (b) have never been suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs based on a mandatory exclusion under 42 U.S.C. § 1396a-7(a).~~

~~I hereby further certify that the applicant listed above and its agents will comply with all applicable laws including, without limitation, Medicare and Medi-Cal laws and regulations, and CalOptima's Compliance Program. I acknowledge and agree that CalOptima may recoup reimbursement paid to any ineligible provider.~~

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

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Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes, and/or terminations to a provider's network affiliates. If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply)	☐ **Medi-Cal** ☐ **OneCare** ☐ **PACE** ☐ **OneCare Connect**

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME		PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE / ZIP
REMIT ADDRESS		CITY	STATE / ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CHDP ☐ CPSP	

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVLEGES

1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The Provider Relations (PR) Representative (Rep) must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR Rep.

Effective Date **(required)**:	Date Credentialing Completed (within the last 3 years)	Current Facility Site Review Date (within last 3 years)
PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH** ☐ **PCP** ☐ **SPECIALIST**	☐ **Open Panel /** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)		
	☐ **PCP** ☐ **SPECIALIST**	☐ **Open Panel /** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ **TAX I.D. CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax I.D. (required):	Previous Tax I.D.	New Tax I.D.

ACTION REQUIREMENTS cont. (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR Rep.

Effective Date (required):	☐ **PCP** ☐ **SPECIALIST** ☐ **ANCILLARY**

Date CalOptima received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member / payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of Members Impacted (As of Date Received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____ ☐ **OneCare Connect** _____

Date Member Notice was mailed (if Member Notice has not been sent, please put anticipated date and notify CalOptima if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address, and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a Facility Site Review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three (3) address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person		
Address		City	State	ZIP
Phone	Fax	Office Hours	After-Hours Phone	
Office Manager		E-mail Address		

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		E-mail Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages Spoken by Provider

1. _____ 2. _____ 3. _____

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

CalOptima User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

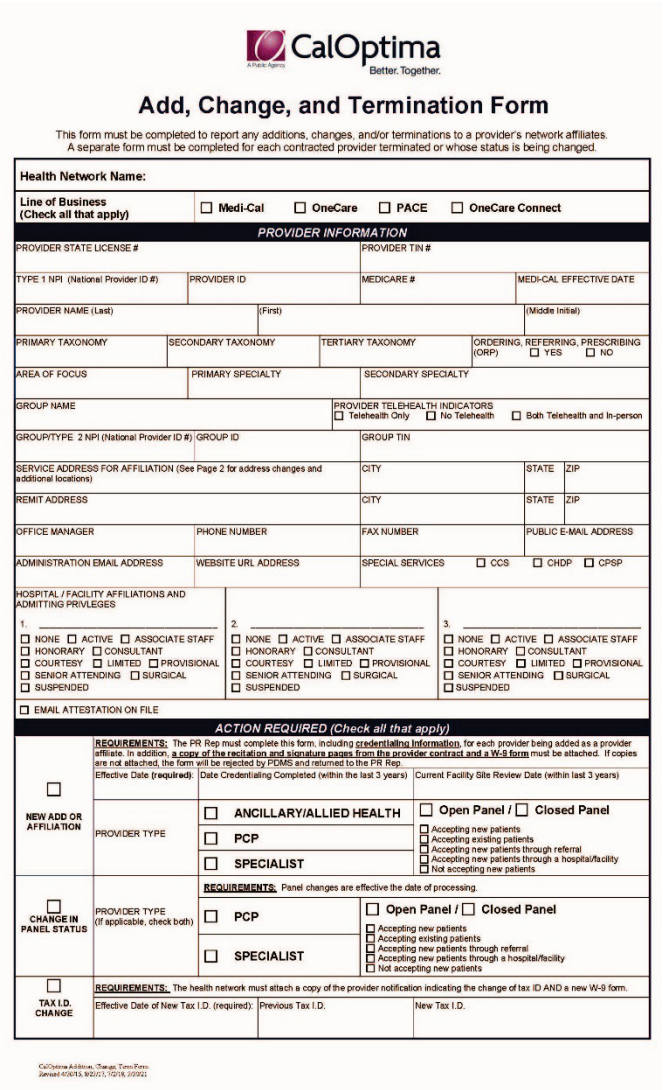
REQUIREMENTS

CalOptima requires its health networks (HN), subdelegates, providers and practitioners to promptly inform us of any changes to information regarding practitioner:

- **Demographics**
- **Credentialing**
- **Panel status** — including accepting new patients, accepting existing patients, accepting through a referral, accepting through a facility or hospital and not accepting new patients
- **Other information requested in this file**

HEALTH NETWORKS

All HNs and subdelegates shall promptly, but no later than five business days from a change in the practitioner's panel status, inform CalOptima of such change. The HN verifies and updates the practitioners' information on a quarterly basis. The HN verification process includes a methodology to audit and confirm the information provided by its practitioners is true and correct. HN maintains records of such verifications and shall provide them during the second and fourth quarters of the year.



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Add, Change, and Termination Form

This form must be completed to report any additions, changes, and/or terminations to a provider's network affiliates. A separate form must be completed for each contracted provider terminated or whose status is being changed.

Health Network Name:

Line of Business (Check all that apply) ☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME		PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
REMIT ADDRESS		CITY	STATE ZIP
OFFICE MANAGER	PHONE NUMBER	FAX NUMBER	PUBLIC E-MAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CHDP ☐ CPSP	

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1.	2.	3.
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The PR Rep must complete this form, including credentialing information, for each provider being added as a provider affiliate. In addition, a copy of the recitation and signature pages from the provider contract and a W-9 form must be attached. If copies are not attached, the form will be rejected by PDMS and returned to the PR Rep.

Effective Date (required): | Date Credentialing Completed (within the last 3 years) | Current Facility Site Review Date (within last 3 years)

PROVIDER TYPE: ☐ ANCILLARY/ALLIED HEALTH ☐ PCP ☐ SPECIALIST

☐ Open Panel / ☐ Closed Panel
☐ Accepting new patients
☐ Accepting existing patients
☐ Accepting new patients through referral
☐ Accepting new patients through a hospital/facility
☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both): ☐ PCP ☐ SPECIALIST

☐ Open Panel / ☐ Closed Panel
☐ Accepting new patients
☐ Accepting existing patients
☐ Accepting new patients through referral
☐ Accepting new patients through a hospital/facility
☐ Not accepting new patients

☐ **TAX I.D. CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax I.D. (required): | Previous Tax I.D. | New Tax I.D.

CalOptima Addition, Change, Term Form
Revised 4/30/15, 9/22/17, 7/2/18, 3/3/21

ACT FORM INSTRUCTIONS

Please read through instructions carefully.

1) Do not change column name, column order and data format, and do not add in new columns.
2) Submit any practitioner (i.e., PCP, specialist, mid-level) participating within your CalOptima network.
3) Submit any practice location (medical office, clinic, etc.) participating within your CalOptima network.
4) Submit any hospital that provides health care services to CalOptima members within your network, regardless of CalOptima contractual relationship.
5) Submit any ancillary facility and its affiliated practitioners that provide health care services to CalOptima members within your network, regardless of CalOptima contractual relationship.
6) All provider types (taxonomy and specialty)
   a. Must be credentialed
   b. Only the taxonomy and specialty that are contracted at the location
   c. Please refer to the taxonomy codes submitted on the sFTP for taxonomy code table.
7) Practice locations must pass Facility Site Review (FSR) — Physician and mid-level.
8) Email completed ACT form and applicable support documents to ProviderOnline@caloptima.org.

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CalOptima User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

HOW TO SUBMIT CALOPTIMA ACT FORM

1) Complete all relevant **sections** of the CalOptima ACT Form.
2) Attached a competed and signed W9.
3) Include a copy of the front of your HN contract and signature page or CCN/COD Contract Summary.
4) Complete a provider profile. Email completed ACT form and applicable support documents to ProviderOnline@caloptima.org.
5) For questions and more information, call the CalOptima Provider Relations department at **714-246-8600.**

Scope of Provider Type

1) **Physician** (individual)
   - Medical Doctor (M.D.)
   - Doctor of Osteopathic Medicine (D.O.)
   - Doctor of Podiatric Medicine (D.P.M.)
2) **Mid-level** (individual)
   - Certified Nurse Practitioners (CNP)
   - Certified Nurse Midwifes (CNM)
   - Physician Assistants (PA)
3) **Hospital**: Any hospital within HN network, regardless of CalOptima's contractual relationship. Samples include, but are not limited to, the following:

- Ambulatory Surgery Center
- Hospital with Acute Care
- Psychiatric Hospital

4) **Ancillary**: Any facility that provides health care services to CalOptima members within HN network, regardless of CalOptima contractual relationship. Examples include but are not limited to the following:

- Adult Day Health Care Center/Community Based Adult Service
- Audiology
- Durable Medical Equipment
- End-Stage Renal Disease Provider/Dialysis Unit/Hemodialysis
- Home Health
- Home Infusion
- Hospice
- Clinical Laboratory
- Long-Term Services and Supports
- Occupational Therapy
- Physical Therapy
- Portable X-Ray Supplier
- Radiology Center
- Rehabilitation Center
- Skilled Nursing Facility
- Transportation Services
- Urgent Care
- Others

Practitioner Practices at Ancillary (individual) — examples include but are not limited to the following:

- Acupuncturist
- Audiologist
- Chiropractor
- Physical Therapist
- Radiation Therapist
- Occupational Therapist
- Speech Therapist

CalOptima User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

WHEN SHOULD I SUBMIT AN ACT REQUEST?

Additions: Term referred to in the Addition, Change and Termination (ACT) process to add a provider, practitioner or facility to CalOptima's system. Health networks and subdelegates are recommended to submit ACT forms and applicable documentation as outlined in this policy when adding a provider, practitioner or facility pursuant to the terms of the agreement. To add an additional location to an existing provider, check the additional location box on Page 2 of the ACT form.

Changes: Term referred to in the Addition, Change and Termination (ACT) process to make a demographic or other change to a provider, practitioner or facility in CalOptima's system. Health networks and subdelegates are recommended to submit ACT forms and applicable documentation as outlined in this policy when making demographic or other changes to the CalOptima system pursuant to the terms of the agreement.

Terminations: Term referred to in the Addition, Change and Termination (ACT) process when terminating a provider, practitioner or facility from CalOptima's system. Health networks and subdelegates are recommended to submit notification of terminations pursuant to the terms of the agreement.

ADDITIONAL SUBMISSION RECOMMENDATIONS

Additions: When making an addition request, the group name, National Provider Identifier (NPI) and tax identification number (TIN) must all correspond. In the event your submission consists of non-corresponding identifiers, it will not be honored.

Terminations: When requesting a termination of a provider's TIN, you must submit the group NPI along with the TIN.

Health Networks and Subdelegates

- Health networks and providers are recommended to take the following steps when requesting to move a provider from one group NPI to another group NPI:
  1. Submit ACT Termination form to remove the provider from the CalOptima system.
  2. Submit ACT Addition form and applicable documentation as outlined in EE.1101 to add the provider to the CalOptima system with the new group NPI.

  Note: Each of the above steps must be done separately.
- If you are adding or changing the address of a primary care provider (PCP), you must include the date of request along with a Facility Site Review (FSR) completion form with your submission request.

Email completed ACT form and applicable support documents to ProviderOnline@caloptima.org.

Disclaimer — For directory data integrity purposes, CalOptima will limit the registration of office locations outside of Orange County for providers with multiple sites to the following cities: **Whittier, La Mirada, Cerritos, Hawaiian Gardens, Long Beach, Lakewood, La Habra Heights, Hacienda Heights, Diamond Bar and Rowland Heights**. Provider office locations outside of these cities will NOT be loaded in the CalOptima Provider Directory.

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Add, Change, and Termination Form

This form must be completed to report any additions, changes, and/or terminations to a provider's network affiliates.
A separate form must be completed for each contracted provider terminated or whose status is being changed.

Health Network Name:				
Line of Business (Check all that apply)	☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect			
PROVIDER INFORMATION				
PROVIDER STATE LICENSE #		PROVIDER TIN #		
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE	
PROVIDER NAME (Last)	(First)	(Middle Initial)		
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO	
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY		
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person			
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN		
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE	ZIP
REMIT ADDRESS		CITY	STATE	ZIP
OFFICE MANAGER	PHONE NUMBER	FAX NUMBER	PUBLIC E-MAIL ADDRESS	
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CHDP ☐ CPSP		
HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVLEGES				
1. _____ ☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	2. _____ ☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	3. _____ ☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED		
☐ EMAIL ATTESTATION ON FILE				

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**	**REQUIREMENTS:** The PR Rep must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by PDMS and returned to the PR Rep.		
	Effective Date **(required)**:	Date Credentialing Completed (within the last 3 years)	Current Facility Site Review Date (within last 3 years)
	PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH**	☐ **Open Panel** / ☐ **Closed Panel**
		☐ **PCP**	☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients
		☐ **SPECIALIST**	
☐ **CHANGE IN PANEL STATUS**	PROVIDER TYPE (If applicable, check both)	**REQUIREMENTS:** Panel changes are effective the date of processing.	
		☐ **PCP**	☐ **Open Panel** / ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients
		☐ **SPECIALIST**	
☐ **TAX I.D. CHANGE**	**REQUIREMENTS:** The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.		
	Effective Date of New Tax I.D. (required):	Previous Tax I.D.	New Tax I.D.

Sample

Addition

CalOptima User Guide

ADD, CHANGE, AND TERMINATION (ACT) FORM

ACTION REQUIRED cont. (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR Rep.

Effective Date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider Retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider Deceased
- ☐ Provider unwilling to accept member / payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of Members Impacted (As of Date Received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____ ☐ **OneCare Connect** _____

Date Member Notice was mailed (if Member Notice has not been sent, please put anticipated date and notify CalOptima if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address, and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a Facility Site Review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three (3) address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		E-mail Address		

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		E-mail Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages Spoken by Provider

2. _____ 2. _____ 3. _____

☐ OTHER

Comments:

I certify that the above information is true, accurate and complete to the best of my knowledge and that I am authorized to execute this document on behalf of the applicant. I understand that incorrect or inaccurate information may affect the applicant's eligibility to receive CalOptima reimbursement and that the applicant must report changes in the above information to the CalOptima Provider Enrollment Unit. I hereby further declare that the applicant listed above and its agents (a) have not been convicted of a criminal offense related to health care in the past seven (7) years; and (b) have never been suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs based on a mandatory exclusion under 42 U.S.C. § 1396a-7(a).

I hereby further certify that the applicant listed above and its agents will comply with all applicable laws including, without limitation, Medicare and Medi-Cal laws and regulations, and CalOptima's Compliance Program. I acknowledge and agree that CalOptima may recoup reimbursement paid to any ineligible provider.

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

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CalOptima User Guide

ADD, CHANGE, AND TERMINATION (ACT) FORM

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Add, Change, and Termination Form

This form must be completed to report any additions, changes, and/or terminations to a provider's network affiliates.
A separate form must be completed for each contracted provider terminated or whose status is being changed.

Health Network Name:				
Line of Business (Check all that apply)	☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect			
PROVIDER INFORMATION				
PROVIDER STATE LICENSE #		PROVIDER TIN #		
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE	
PROVIDER NAME (Last)	(First)	(Middle Initial)		
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO	
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY		
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person			
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN		
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE	ZIP
REMIT ADDRESS		CITY	STATE	ZIP
OFFICE MANAGER	PHONE NUMBER	FAX NUMBER	PUBLIC E-MAIL ADDRESS	
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CHDP ☐ CPSP		

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVLEGES		
1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**	**REQUIREMENTS:** The PR Rep must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by PDMS and returned to the PR Rep.		
	Effective Date **(required)**:	Date Credentialing Completed (within the last 3 years)	Current Facility Site Review Date (within last 3 years)
	PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH** ☐ **PCP** ☐ **SPECIALIST**	☐ **Open Panel / ☐ Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients
☐ **CHANGE IN PANEL STATUS**	PROVIDER TYPE (If applicable, check both)	**REQUIREMENTS:** Panel changes are effective the date of processing.	
		☐ **PCP** ☐ **SPECIALIST**	☐ **Open Panel / ☐ Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients
☐ **TAX I.D. CHANGE**	**REQUIREMENTS:** The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.		
	Effective Date of New Tax I.D. (required):	Previous Tax I.D.	New Tax I.D.

CalOptima Addition, Change, Term Form
Revised 4/30/15, 8/23/17, 7/2/18, 3/30/21

Sample

Change

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ADD, CHANGE, AND TERMINATION (ACT) FORM

ACTION REQUIRED cont. (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR Rep.

Effective Date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider Retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider Deceased
- ☐ Provider unwilling to accept member / payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of Members Impacted (As of Date Received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____ ☐ **OneCare Connect** _____

Date Member Notice was mailed (if Member Notice has not been sent, please put anticipated date and notify CalOptima if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address, and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a Facility Site Review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three (3) address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		E-mail Address		

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		E-mail Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages Spoken by Provider

2. _____ 2. _____ 3. _____

☐ OTHER

Comments:

I certify that the above information is true, accurate and complete to the best of my knowledge and that I am authorized to execute this document on behalf of the applicant. I understand that incorrect or inaccurate information may affect the applicant's eligibility to receive CalOptima reimbursement and that the applicant must report changes in the above information to the CalOptima Provider Enrollment Unit. I hereby further declare that the applicant listed above and its agents (a) have not been convicted of a criminal offense related to health care in the past seven (7) years; and (b) have never been suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs based on a mandatory exclusion under 42 U.S.C. § 1396a-7(a).

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PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

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ADD, CHANGE, AND TERMINATION (ACT) FORM

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Health Network Name:				
Line of Business (Check all that apply)	☐ Medi-Cal ☐ OneCare ☐ PACE ☐ OneCare Connect			
PROVIDER INFORMATION				
PROVIDER STATE LICENSE #		PROVIDER TIN #		
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE	
PROVIDER NAME (Last)	(First)		(Middle Initial)	
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO	
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY		
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person			
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN		
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE	ZIP
REMIT ADDRESS		CITY	STATE	ZIP
OFFICE MANAGER	PHONE NUMBER	FAX NUMBER	PUBLIC E-MAIL ADDRESS	
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CHDP ☐ CPSP		

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVLEGES		
1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The PR Rep must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by PDMS and returned to the PR Rep.

Effective Date **(required)**:	Date Credentialing Completed (within the last 3 years)	Current Facility Site Review Date (within last 3 years)
PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH** ☐ **PCP** ☐ **SPECIALIST**	☐ **Open Panel / ☐ Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)		
	☐ **PCP**	☐ **Open Panel / ☐ Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients
	☐ **SPECIALIST**	

☐ **TAX I.D. CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax I.D. (required):	Previous Tax I.D.	New Tax I.D.

CalOptima Addition, Change, Term Form
Revised 4/30/15, 8/23/17, 7/2/18, 3/30/21

Sample

Termination

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ADD, CHANGE, AND TERMINATION (ACT) FORM

ACTION REQUIRED cont. (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR Rep.

Effective Date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider Retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider Deceased
- ☐ Provider unwilling to accept member / payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of Members Impacted (As of Date Received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____ ☐ **OneCare Connect** _____

Date Member Notice was mailed (if Member Notice has not been sent, please put anticipated date and notify CalOptima if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address, and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a Facility Site Review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three (3) address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ]ADD [ ]TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		E-mail Address		

SERVICE ADDRESS **Check one: [ ]ADD [ ]TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		E-mail Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages Spoken by Provider

2. _____ 2. _____ 3. _____

☐ OTHER

Comments:

I certify that the above information is true, accurate and complete to the best of my knowledge and that I am authorized to execute this document on behalf of the applicant. I understand that incorrect or inaccurate information may affect the applicant's eligibility to receive CalOptima reimbursement and that the applicant must report changes in the above information to the CalOptima Provider Enrollment Unit. I hereby further declare that the applicant listed above and its agents (a) have not been convicted of a criminal offense related to health care in the past seven (7) years; and (b) have never been suspended, excluded or otherwise ineligible to participate in Federal and/or State health care programs based on a mandatory exclusion under 42 U.S.C. § 1396a-7(a).

I hereby further certify that the applicant listed above and its agents will comply with all applicable laws including, without limitation, Medicare and Medi-Cal laws and regulations, and CalOptima's Compliance Program. I acknowledge and agree that CalOptima may recoup reimbursement paid to any ineligible provider.

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

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ADD, CHANGE, AND TERMINATION (ACT) FORM

ADDENDUM

CalOptima requests use of the email header naming convention reflected below to ensure compliance with turn-around guidelines. Please use the headers below; do not add "Urgent" or deviate from the headers below.

Naming Convention for Email Subject Headers

Provider

11-1-18 ACT – PCP Term Monarch Moore, Hezekiah N MD (A12345) (Medi-Cal, OC, OCC)

Submission Date | Provider Type | Request Type | Health Network | Provider Last Name | Provider First Name | License # | Program

Provider Email Subject Header Naming Convention:
Submission Date: Date form is submitted
Provider Type: PCP, SPC, MIDLEVEL, ANC
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Provider Health Network Affiliation
Provider Last Name: Last name of provider based on State license
Provider First Name: First Name of provider based on State license
License #: State license number
Program: MC = Medi-Cal, OC = OneCare, OCC = OneCare Connect

Facility

11-1-18 ACT – Demo Change CCN – Kindred Hospital Santa Ana (1234567891) (Medi-Cal, OC, OCC)

Submission Date | Request Type | Health Network | Facility Nane | Facility NPI | Program

Facility Email Subject Header Naming Convention:
Submission Date: Date form is submitted
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Facility Health Network Affiliation
Facility Name: Facility Name as reflected on Agreement
Facility NPI: Facility NPI
Program: MC = Medi-Cal, OC = OneCare, OCC = OneCare Connect

Group

11-1-18 ACT – Tax Change AltaMed – Fairview Medical Group (99-9999999)_(1234567897) (Medi-Cal, OC, OCC)

Group Email

Submission Date | Request Type | Health Network | Group Name | Tax ID# | NPI# | Program

Subject Header Naming Convention:
Submission Date: Date form is submitted
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Provider's Health Network Affiliation
Group Name: Name of group as reflected on Agreement
Tax-ID: Group Tax ID on accompanying W-9
NPI #: Type 2 NPI
Program: MC = Medi-Cal, OC = OneCare, OCC = OneCare Connect

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ADD, CHANGE, AND TERMINATION (ACT) FORM

DEFINITIONS

HEALTH NETWORK NAME	Health network group name
PROGRAM	The program/product code the practitioner affiliates with CalOptima at the practice location. Program codes include: MC = Medi-Cal; OC = OneCare; OCC = OCC; PACE = PACE If practitioner has more than one program, insert additional program records (rows) for each.
CA LICENSE NUMBER	California license number of the practitioner. License type letter and license number should be contiguous with no space in between. (NP, CNM and PA for mid-level; A, C, G and 20A for MD and DO; E for DPM).
PROVIDER TIN	The individual federal tax ID of the practitioner. Note: it is NOT a provider group, IPA or location's TIN. Numbers only — no space and no special characters.
TYPE 1 NPI	National provider identifier of the practitioner (NPI type 1, 10 digits)
PROVIDER ID	The individual identification number assigned by CalOptima to be used for existing providers for demographic changes and terminations (9 digits = solo practitioner; 12 digits = affiliated to a group)
MEDICARE NUMBER	CMS Certification Number is used to verify that a provider has been Medicare-/Medicaid-certified and for what type of services. Formerly known as 1) OSCAR provider number, 2) Medicare Identification Number, or 3) Medicare/Medicaid Identification Number. Reference: CMS Manual System, Pub 100-07 State Operations Provider Certification
MEDI-CAL EFFECTIVE DATE	Effective date the provider received a Medicaid provider number
PROVIDER LAST NAME	Full last name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure such as certain qualified autism service providers, it means the last name appearing on the certification by a national entity.
PROVIDER FIRST NAME	Full first name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure such as certain qualified autism service providers, it means the first name appearing on the certification by a national entity.
PROVIDER MIDDLE NAME	Full middle name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure such as certain qualified autism service providers, it means the middle name appearing on the certification by a national entity.
TAXONOMY (PRIMARY, SECONDARY, TERTIARY)	The taxonomy code of the practitioner's specialty. Please refer to the taxonomy crosswalk provided by CalOptima.
FACILITY PHYSICAL ACCESSIBILITY COMPLIANCE	Meets facility Americans with Disabilities Act (ADA) handicapped compliance.
ORDERING, REFERRING, PRESCRIBING (ORP)	State or federal regulated certification for providers who order, refer or prescribe
AREA OF FOCUS	The specific focus of the practitioner's specialty
PRIMARY SPECIALTY	The primary specialty for which the practitioner is contracted to provide services at the location. (When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.)

SECONDARY SPECIALTY	The secondary specialty for which the practitioner is contracted to provide services at the location. (When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.)
GROUP NAME	Full name of medical group practitioner is affiliated with based on contract
GROUP/TYPE 2 NPI	National provider identifier of the medical group (NPI type 2, 10 digits)
GROUP ID	The identification number assigned by CalOptima to be used for existing medical groups for demographic changes and terminations (9 digits)
GROUP TIN	The group federal tax ID of the practitioner. Numbers only — no spaces and no special characters
SERVICE LOCATION STREET	USPS CASS-certified delivery address street names and their ranges at the practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.
SERVICE LOCATION CITY	City where the practice location is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication 28)
SERVICE LOCATION COUNTY	County where the practice is located
SERVICE LOCATION STATE	State where the practice is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication 28)
SERVICE LOCATION ZIP	ZIP code in which the practice is located (5 digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication 28).
REMIT STREET	USPS CASS-certified pay-to address street names, secondary address unit designators and their ranges for this practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.
REMIT CITY	City of pay-to location. Must be USPS CASS-certified and use USPS postal addressing standard (Publication 28)
REMIT STATE	State of pay-to location. Must be USPS CASS-certified and use USPS postal addressing standard (Publication 28)
REMIT ZIP	ZIP code in which the pay-to address is located (5 digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication 28)
OFFICE MANAGER	Name of the contact person at the practice location
PHONE NUMBER	Phone number at practice location. 10-digit number only and no space or special character.
FAX NUMBER	Fax number at practice location. 10-digit number only and no space or special character.
PUBLIC EMAIL	Email address the practitioner would like to be published on the directory for inquiries from CalOptima members. Note: it is NOT site contact person's email.
ADMINISTRATION EMAIL ADDRESS	Email address the practitioner uses for business correspondence with CalOptima only. Note: it is NOT site contact person's email. It is internal use between CalOptima and practitioner only.

CalOptima User Guide

ADD, CHANGE, AND TERMINATION (ACT) FORM

WEBSITE URL ADDRESS	The webpage or other online resource for the practice location. Use complete URL syntax including scheme, two slashes, authority part and path with optional query and fragment.
SPECIAL SERVICES	Check all that apply: CCS, CHDP, CPSP, etc.
HOSPITAL / FACILTIY AFFILIATIONS ADMITTING PRIV	The name of CalOptima contracted hospital where the practitioner is on staff and/or has admitting privileges. Types of privileges include: NONE, ACTIVE, ASSOCIATE STAFF, HONORARY, CONSULTANT, COURTESY, LIMITED, PROVISIONAL, SENIOR ATTENDING, SURGICAL, SUSPENDED
ATTESTATION	Yes = HN has received a provider attestation; No = HN has not received a provider attestation. Note it won't be published in provider directory now, but by providing the public email, the provider acknowledges and agrees that the email is for patient communications, regularly monitored, maintained in manner consistent with state and federal health privacy laws, including Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality of Medical Information Act (CMIA).
ACCEPTING NEW PATIENTS	Accepting new patients; No = Not accepting new patients
ACCEPTING EXISTING PATIENTS	Accepting existing patients; No = Not accepting existing patients
ACCEPTING THROUGH REFERRAL	Accepting through referral; No = Not accepting through referral
ACCEPTING THROUGH HOSPITAL FACILITY	Accepting through hospital facility; No = Not accepting through referral
NOT ACCEPTING NEW PATIENTS	Not accepting new patients
PANEL STATUS	The providers panel status is "Open" or "Closed"
OFFICE HOUR SUNDAY	Office hours of the practice location on Sunday. "CLOSED" if not open. Format is "HH:MI-HH:MI," 11 digits exactly and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30 a.m.–12 p.m. and 1–5 p.m., then put "08:30–17:00."
OFFICE HOUR MONDAY	Office hours of the practice location on Monday. "CLOSED" if not open. Format is "HH:MI-HH:MI," 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30 a.m.–12 p.m. and 1–5 p.m., then put "08:30–17:00."
OFFICE HOUR TUESDAY	Office hours of the practice location on Tuesday. "CLOSED" if not open. Format is "HH:MI-HH:MI," 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30 a.m.–12 p.m. and 1–5 p.m., then put "08:30–17:00."
OFFICE HOUR WEDNESDAY	Office hours of the practice location on Wednesday. "CLOSED" if not open. Format is "HH:MI-HH:MI," 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30 a.m.–12 p.m. and 1–5 p.m., then put "08:30–17:00."
OFFICE HOUR THURSDAY	Office hours of the practice location on Thursday. "CLOSED" if not open. Format is "HH:MI-HH:MI," 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30 a.m.–12 p.m. and 1–5 p.m., then put "08:30–17:00."
OFFICE HOUR FRIDAY	Office hours of the practice location on Friday. "CLOSED" if not open. Format is "HH:MI-HH:MI," 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30 a.m.–12 p.m. and 1–5 p.m., then put "08:30–17:00."
OFFICE HOUR SATURDAY	Office hours of the practice location on Saturday. "CLOSED" if not open. Format is "HH:MI-HH:MI," 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30 a.m.–12 p.m. and 1–5 p.m., then put "08:30–17:00."
SERVICE LOCATION PHONE AFTER-HOURS	Phone number at practice location after hours in case of emergency or urgency. 10-digit number only and no space or special characters.
STAFF LANGUAGE	The language(s) spoken by office staff (not providers) at practice location. Use Language tab.

PRACTITIONER LANGUAGE	The language practitioner speaks. Use Language tab.
MEMBER AGE MIN	Use comments section: CalOptima member's minimum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no limit = 0.
MEMBER AGE MAX	Use comments section: CalOptima member's maximum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no limit = 150.
GENDER RESTRICTION	Use comments section: If the service at the practice location is only accessible to specific gender of CalOptima member. F = female member only; M = male member only; NR = no restriction.
TELEHEALTH SITE INDICATORS	Site indicator: Telehealth Only, No Telehealth or Both Telehealth and In-Person. Use Telehealth Tab.

Health Care Provider Taxonomy

VERSION 21.1
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Allopathic & Osteopathic Physicians

Allergy & Immunology

207K00000X Allergy & Immunology Physician

An allergist-immunologist is trained in evaluation, physical and laboratory diagnosis, and management of disorders involving the immune system. Selected examples of such conditions include asthma, anaphylaxis, rhinitis, eczema, and adverse reactions to drugs, foods, and insect stings as well as immune deficiency diseases (both acquired and congenital), defects in host defense, and problems related to autoimmune disease, organ transplantation, or malignancies of the immune system.

Source: American Board of Medical Specialties, 2007, www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Allergy and Immunology, 2007. http://www.abai.org/ No subspecialty certificates in allergy and immunology are offered by the American Board of Allergy and Immunology (ABAI). The ABAI, however, does offer formal special pathways for physicians seeking dual certification in allergy/immunology and pediatric pulmonology; allergy/immunology and pediatric rheumatology; and allergy/immunology and adult rheumatology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Allergy

207KA0200X Allergy Physician

Definition to come...

Effective Date 4/1/2003

Specialization: Clinical & Laboratory Immunology

207KI0005X Clinical & Laboratory Immunology (Allergy & Immunology) Physician

Definition to come...

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Anesthesiology

207L00000X Anesthesiology Physician

An anesthesiologist is trained to provide pain relief and maintenance, or restoration, of a stable condition during and immediately following an operation or an obstetric or diagnostic procedure. The anesthesiologist assesses the risk of the patient undergoing surgery and optimizes the patient's condition prior to, during and after surgery. In addition to these management responsibilities, the anesthesiologist provides medical management and consultation in pain management and critical care medicine. Anesthesiologists diagnose and treat acute, long-standing and cancer pain problems; diagnose and treat patients with critical illnesses or severe injuries; direct resuscitation in the care of patients with cardiac or respiratory emergencies, including the need for artificial ventilation; and supervise post-anesthesia recovery.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Anesthesiology, 2007. http://www.theaba.org/; American Osteopathic Board of Anesthesiology, 2007, http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Anesthesiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Anesthesiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Addiction Medicine

207LA0401X Addiction Medicine (Anesthesiology) Physician

An anesthesiologist who specializes in the diagnosis and treatment of addictions.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Anesthesiology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Critical Care Medicine

207LC0200X Critical Care Medicine (Anesthesiology) Physician

An anesthesiologist, who specializes in critical care medicine diagnoses, treats and supports patients with multiple organ dysfunction. This specialist may have administrative responsibilities for intensive care units and may also facilitate and coordinate patient care among the primary physician, the critical care staff and other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Anesthesiology, 2007. http://www.theaba.org/; American Osteopathic Board of Anesthesiology, 2007, http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Anesthesiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Anesthesiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Anesthesiology

Specialization: Hospice and Palliative Medicine

207LH0002X Hospice and Palliative Medicine (Anesthesiology) Physician

An anesthesiologist with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Pain Medicine

207LP2900X Pain Medicine (Anesthesiology) Physician

An anesthesiologist who provides a high level of care, either as a primary physician or consultant, for patients experiencing problems with acute, chronic and/or cancer pain in both hospital and ambulatory settings. Patient care needs are also coordinated with other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Anesthesiology, 2007. http://www.theaba.org/; American Osteopathic Board of Anesthesiology, 2007, http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Anesthesiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Anesthesiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Anesthesiology

207LP3000X Pediatric Anesthesiology Physician

An anesthesiologist who has had additional skill and experience in and is primarily concerned with the anesthesia, sedation, and pain management needs of infants and children. A pediatric anesthesiologist generally provides services including the evaluation of complex medical problems in infants and children when surgery is necessary, planning and care for children before and after surgery, pain control, anesthesia and sedation for any procedures out of the operating room such as MRI, CT scan, and radiation therapy.

Source: American Academy of Pediatrics, www.aap.org [7/1/2006: new]

Effective Date 10/1/200

Allopathic & Osteopathic Physicians

Clinical Pharmacology

208U00000X Clinical Pharmacology Physician

Clinical pharmacology encompasses the spectrum of activities related to the discovery, development, regulation, and utilization of safe and effective drugs.

Source: American Society for Clinical Pharmacology and Therapeutics, 2008 [7/1/2008: modified definition] Additional Resources: Clinical pharmacology is a recognized fellowship program for physicians, pharmacists, and post-doctoral researchers delivered through medical education institutions accredited by the American Board of Clinical Pharmacology. http://www.ascpt.org/; American Board of Clinical Pharmacology http://www.abcp.net/

Effective Date 4/1/2003

Colon & Rectal Surgery

208C00000X Colon & Rectal Surgery Physician

A colon and rectal surgeon is trained to diagnose and treat various diseases of the intestinal tract, colon, rectum, anal canal and perianal area by medical and surgical means. This specialist also deals with other organs and tissues (such as the liver, urinary and female reproductive system) involved with primary intestinal disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Colon and Rectal Surgery, 2007. http://www.abcrs.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Colon and Rectal Surgery. Colon and rectal surgeons have the expertise to diagnose and often manage anorectal conditions such as hemorrhoids, fissures (painful tears in the anal lining), abscesses and fistulae (infections located around the anus and rectum) in the office setting. They also treat problems of the intestine and colon, and perform endoscopic procedures to evaluate and treat problems such as cancer, polyps (precancerous growths) and inflammatory conditions.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Dermatology

207N00000X Dermatology Physician

A dermatologist is trained to diagnose and treat pediatric and adult patients with benign and malignant disorders of the skin, mouth, external genitalia, hair and nails, as well as a number of sexually transmitted diseases. The dermatologist has had additional training and experience in the diagnosis and treatment of skin cancers, melanomas, moles and other tumors of the skin, the management of contact dermatitis and other allergic and nonallergic skin disorders, and in the recognition of the skin manifestations of systemic (including internal malignancy) and infectious diseases. Dermatologists have special training in dermatopathology and in the surgical techniques used in dermatology. They also have expertise in the management of cosmetic disorders of the skin such as hair loss and scars and the skin changes associated with aging.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Dermatology, 2007. http://www.abderm.org/ Board certification is provided by the American Board of Dermatology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Dermatology

Specialization: Clinical & Laboratory Dermatological Immunology

207NI0002X Clinical & Laboratory Dermatological Immunology Physician

A dermatologist who utilizes various specialized laboratory procedures to diagnose disorders characterized by defective responses of the body's immune system. Immunodermatologists also may provide consultation in the management of these disorders and administer specialized forms of therapy for these diseases.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Dermatology, 2007. http://www.abderm.org/ Board certification is provided by the American Board of Dermatology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Dermatopathology

207ND0900X Dermatopathology Physician

A dermatopathologist has the expertise to diagnose and monitor diseases of the skin including infectious, immunologic, degenerative and neoplastic diseases. This entails the examination and interpretation of specially prepared tissue sections, cellular scrapings and smears of skin lesions by means of routine and special (electron and fluorescent) microscopes.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Dermatology, 2007. http://www.abderm.org/; American Osteopathic Board of Dermatology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Dermatology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Dermatology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: MOHS-Micrographic Surgery

207ND0101X MOHS-Micrographic Surgery Physician

The highly-trained surgeons that perform Mohs Micrographic Surgery are specialists both in dermatology and pathology. With their extensive knowledge of the skin and unique pathological skills, they are able to remove only diseased tissue, preserving healthy tissue and minimizing the cosmetic impact of the surgery. Mohs surgeons who belong to the American College of Mohs Surgery (ACMS) have completed a minimum of one year of fellowship training at one of the ACMS-approved training centers in the U.S.

Source: American College of Mohs Surgery, 2007 [1/1/2008: added definition, added source] Additional Resources: Additional Resources: http://www.mohscollege.org/; American Board of Dermatology, 2007. http://www.abderm.org/

Effective Date 4/1/2003 Last Modified Date 1/1/2008

Allopathic & Osteopathic Physicians

Dermatology

Specialization: Pediatric Dermatology

207NP0225X Pediatric Dermatology Physician

A pediatric dermatologist has, through additional special training, developed expertise in the treatment of specific skin disease categories with emphasis on those diseases which predominate in infants, children and adolescents.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: changed definition, added source] Additional Resources: American Board of Dermatology, 2007, http://www.abderm.org/ A subspecialty certificate was approved by ABMS in 2000. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Procedural Dermatology

207NS0135X Procedural Dermatology Physician

Procedural Dermatology, a subspecialty of Dermatology, encompassing a wide variety of surgical procedures and methods to remove or modify skin tissue for health or cosmetic benefit. These methods include scalpel surgery, laser surgery, chemical surgery, cryosurgery (liquid nitrogen), electrosurgery, aspiration surgery, liposuction, injection of filler substances, and Mohs micrographic controlled surgery (a special technique for the removal of growths, especially skin cancers).

Source: American Board of Dermatology, 2007, www.abderm.org [1/1/2008: definition added, source added, title changed] Additional Resources: Some ABMS board certified dermatologists have completed a one-year ACGME approved fellowship in Procedural Dermatology, which has been offered since 2003. At this time the ABD does not offer subspecialty certification in Procedural Dermatology.

Effective Date 4/1/2003 Last Modified Date 1/1/2008

Electrodiagnostic Medicine

204R00000X Electrodiagnostic Medicine Physician

Electrodiagnostic medicine is the medical subspecialty that applies neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. Qualified physicians are trained in performing electrophysiological testing and interpretation of the test data. They require knowledge in anatomy, physiology, kinesiology, histology, and pathology of the brain, spinal cord, autonomic nerves, cranial nerves, peripheral nerves, neuromuscular junction, and muscles. They must know clinical features and treatment of diseases of the central, peripheral, and autonomic nervous systems, as well as those of neuromuscular junction and muscle. Physicians also require special knowledge about electric signal processing, including waveform analysis, electronics and instrumentation, stimulation and recording equipment, and statistics.

Source: American Association of Neuromuscular & Electrodiagnostic Medicine, 2011. www.aanem.org [1/1/2011: new] Additional Resources: American Board of Electrodiagnostic Medicine, 2011. www.abemexam.org

Effective Date 4/1/2011

Allopathic & Osteopathic Physicians

Emergency Medicine

207P00000X Emergency Medicine Physician

An emergency physician focuses on the immediate decision making and action necessary to prevent death or any further disability both in the pre-hospital setting by directing emergency medical technicians and in the emergency department. The emergency physician provides immediate recognition, evaluation, care, stabilization and disposition of a generally diversified population of adult and pediatric patients in response to acute illness and injury.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Emergency Medicine, 2007. http://www.abem.org/public/; American Osteopathic Board of Emergency Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Emergency Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Emergency Medical Services

207PE0004X Emergency Medical Services (Emergency Medicine) Physician

An emergency medicine physician who specializes in non-hospital based emergency medical services (e.g., disaster site, accident scene, transport vehicle, etc.) to provide pre-hospital assessment, treatment, and transport patients.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) is issued by the American Osteopathic Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Hospice and Palliative Medicine

207PH0002X Hospice and Palliative Medicine (Emergency Medicine) Physician

An emergency medicine physician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Emergency Medicine

Specialization: Medical Toxicology

207PT0002X Medical Toxicology (Emergency Medicine) Physician

Medical toxicologists are physicians who specialize in the prevention, evaluation, treatment and monitoring of injury and illness from exposures to drugs and chemicals, as well as biological and radiological agents. Medical toxicologists care for people in clinical, academic, governmental and public health settings, and provide poison control center leadership. Important areas of medical toxicology include acute drug poisoning, adverse drug events, drug abuse, addiction and withdrawal, chemicals and hazardous materials, terrorism preparedness, venomous bites and stings and environmental and workplace exposures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Emergency Medicine, 2007. http://www.abem.org/public/. American Osteopathic Board of Emergency Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Emergency Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Emergency Medicine

207PP0204X Pediatric Emergency Medicine (Emergency Medicine) Physician

Pediatric Emergency Medicine is a clinical subspecialty that focuses on the care of the acutely ill or injured child in the setting of an emergency department.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Emergency Medicine, 2007. http://www.abem.org/public/ Board certification is provided by the American Board of Emergency Medicine. Board certification for Medical Doctors (MDs) is provided by the American Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Emergency Medicine

Specialization: Sports Medicine

207PS0010X Sports Medicine (Emergency Medicine) Physician

An emergency physician with special knowledge in sports medicine is responsible for continuous care in the field of sports medicine, not only for the enhancement of health and fitness, but also for the prevention and management of injury and illness. A sports medicine physician has knowledge and experience in the promotion of wellness and the role of exercise in promoting a healthy lifestyle. Knowledge of exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation and epidemiology is essential to the practice of sports medicine.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Emergency Medicine, 2007. http://www.abem.org/public/. American Osteopathic Board of Emergency Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Emergency Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Undersea and Hyperbaric Medicine

207PE0005X Undersea and Hyperbaric Medicine (Emergency Medicine) Physician

A specialist who treats decompression illness and diving accident cases and uses hyperbaric oxygen therapy to treat such conditions as carbon monoxide poisoning, gas gangrene, non-healing wounds, tissue damage from radiation and burns, and bone infections. This specialist also serves as a consultant to other physicians in all aspects of hyperbaric chamber operations, and assesses risks and applies appropriate standards to prevent disease and disability in divers and other persons working in altered atmospheric conditions.

Source: American Board of Emergency Medicine [7/1/2008: source added, additional resources added] Additional Resources: Additional Resources: www.abem.org & American Board of Preventive Medicine www.abprevmed.org

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Family Medicine

207Q00000X Family Medicine Physician

Family Medicine is the medical specialty which is concerned with the total health care of the individual and the family. It is the specialty in breadth which integrates the biological, clinical, and behavioral sciences. The scope of family medicine is not limited by age, sex, organ system, or disease entity.

Source: American Board of Family Medicine [1/1/2007: changed title; 7/1/2007: added definition, added source; 7/1/2017: modified definition]

Note: The American Osteopathic Board of Family Physicians certification includes extensive use of Osteopathic Manipulative Treatment (OMT), which integrates the biological, clinical, and behavioral sciences.

Additional Resources: American Board of Family Medicine, www.theabfm.org. American Osteopathic Board of Family Physicians, www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Physicians or the American Board of Family Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Addiction Medicine

207QA0401X Addiction Medicine (Family Medicine) Physician

A family medicine physician who specializes in the diagnosis and treatment of addictions.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Family Physicians.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Adolescent Medicine

207QA0000X Adolescent Medicine (Family Medicine) Physician

A family medicine physician with multidisciplinary training in the unique physical, psychological and social characteristics of adolescents and their health care problems and needs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Family Medicine, 2007. http://www.theabfm.org/. American Osteopathic Board of Family Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Family Medicine

Specialization: Adult Medicine

207QA0505X Adult Medicine Physician

Definition to come.

Effective Date 4/1/2003

Specialization: Geriatric Medicine

207QG0300X Geriatric Medicine (Family Medicine) Physician

A family medicine physician with special knowledge of the aging process and special skills in the diagnostic, therapeutic, preventive and rehabilitative aspects of illness in the elderly. This specialist cares for geriatric patients in the patient's home, the office, long-term care settings such as nursing homes, and the hospital.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Family Medicine, 2007. http://wwwtheabfm.org/. American Osteopathic Board of Family Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Hospice and Palliative Medicine

207QH0002X Hospice and Palliative Medicine (Family Medicine) Physician

A family medicine physician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Family Medicine

Specialization: Obesity Medicine

207QB0002X Obesity Medicine (Family Medicine) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [10/1/2007: new, 7/1/2015: title and definition modified] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/200

Specialization: Sleep Medicine

207QS1201X Sleep Medicine (Family Medicine) Physician

A Family Medicine Physician who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, 2008, www.aasm.org [7/1/2008: new]

Effective Date 10/1/200

Specialization: Sports Medicine

207QS0010X Sports Medicine (Family Medicine) Physician

A family medicine physician that is trained to be responsible for continuous care in the field of sports medicine, not only for the enhancement of health and fitness, but also for the prevention of injury and illness. A sports medicine physician must have knowledge and experience in the promotion of wellness and the prevention of injury. Knowledge about special areas of medicine such as exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation, epidemiology, physical evaluation, injuries (treatment and prevention and referral practice) and the role of exercise in promoting a healthy lifestyle are essential to the practice of sports medicine. The sports medicine physician requires special education to provide the knowledge to improve the health care of the individual engaged in physical exercise (sports) whether as an individual or in team participation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Family Medicine, 2007. http://www.theabfm.org/. American Osteopathic Board of Family Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

General Practice

208D00000X General Practice Physician

Definition to come...

Effective Date 4/1/2003

Hospitalist

208M00000X Hospitalist Physician

Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research, and leadership related to Hospital Medicine. The term 'hospitalist' refers to physicians whose practice emphasizes providing care for hospitalized patients.

Source: American Society of Hospital Medicine, 2007. http://www.hospitalmedicine.org/ [7/1/2009: definition added] Additional Resources: Hospitalist is a recognized fellowship specialty program offered by many medical institutions. There is no board certification for the specialty at this point.

Effective Date 4/1/2003

Independent Medical Examiner

202C00000X Independent Medical Examiner Physician

A special evaluator not involved with the medical care of the individual examinee that impartially evaluates the care being provided by other practitioners to clarify clinical, disability, liability or other case

Source: American Board of Independent Medical Examiners, www.abime.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Internal Medicine

207R00000X Internal Medicine Physician

A physician who provides long-term, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults and the elderly. Internists are trained in the diagnosis and treatment of cancer, infections and diseases affecting the heart, blood, kidneys, joints and digestive, respiratory and vascular systems. They are also trained in the essentials of primary care internal medicine, which incorporates an understanding of disease prevention, wellness, substance abuse, mental health and effective treatment of common problems of the eyes, ears, skin, nervous system and reproductive organs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Addiction Medicine

207RA0401X Addiction Medicine (Internal Medicine) Physician

An internist doctor of osteopathy that specializes in the treatment of addiction disorders. A doctor of osteopathy that is board eligible/certified by the American Osteopathic Board of Internal Medicine can obtain a Certificate of Added Qualifications in the field of Addiction Medicine.

Source: American Osteopathic Board of Internal Medicine, 2007. [7/1/2008: added definition, added source; 7/1/2011: modified source]

Additional Resources: http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Adolescent Medicine

207RA0000X Adolescent Medicine (Internal Medicine) Physician

An internist who specializes in adolescent medicine is a multi-disciplinary healthcare specialist trained in the unique physical, psychological and social characteristics of adolescents, their healthcare problems and needs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Adult Congenital Heart Disease

207RA0002X Adult Congenital Heart Disease Physician

A physician who specializes in the care and treatment of adults with congenital heart disease. Adult congenital heart disease (ACHD) physicians are trained to understand the complexities of congenital heart disease, anatomy, physiology, surgical repairs, and long-term complications and use that to manage ACHD with acquired heart disease, including heart failure, arrhythmias, and pulmonary hypertension.

Source: American College of Cardiology, www.acc.org [7/1/2018: new]

Effective Date 10/1/201

Specialization: Advanced Heart Failure and Transplant Cardiology

207RA0001X Advanced Heart Failure and Transplant Cardiology Physician

Specialists in Advanced Heart Failure and Transplant Cardiology would participate in the inpatient and outpatient management of patients with advanced heart failure across the spectrum from consideration for high-risk cardiac surgery, cardiac transplantation, or mechanical circulatory support, to pre-and post-operative evaluation and management of patients with cardiac transplants and mechanical support devices, and end-of-life care for patients with end-stage heart failure.

Source: American Board of Internal Medicine, www.abim.org [7/1/2015: new]

Effective Date 10/1/201

Specialization: Allergy & Immunology

207RA0201X Allergy & Immunology (Internal Medicine) Physician

An internist doctor of osteopathy that specializes in the treatment of allergy and immunologic disorders. A doctor of osteopathy that is board eligible/certified by the American Osteopathic Board of Internal Medicine can obtain a Certificate of Special Qualifications in the field of Allergy & Immunology.

Source: American Osteopathic Board of Internal Medicine, 2007. [7/1/2008: added definition, added source; 7/1/2011: modified source]

Additional Resources: http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Cardiovascular Disease

207RC0000X Cardiovascular Disease Physician

An internist who specializes in diseases of the heart and blood vessels and manages complex cardiac conditions such as heart attacks and life-threatening, abnormal heartbeat rhythms.

Source: American Osteopathic Board of Internal Medicine, 2008 [7/1/2008: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, http://www.abim.org/. American Osteopathic Board of Internal Medicine, https://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Clinical & Laboratory Immunology

207RI0001X Clinical & Laboratory Immunology (Internal Medicine) Physician

An internal medicine physician who specializes in clinical and laboratory immunology disease management.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A certification was, but is no longer issued by the American Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Clinical Cardiac Electrophysiology

207RC0001X Clinical Cardiac Electrophysiology Physician

A field of special interest within the subspecialty of cardiovascular disease, specialty of Internal Medicine, which involves intricate technical procedures to evaluate heart rhythms and determine appropriate treatment for them.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Critical Care Medicine

207RC0200X Critical Care Medicine (Internal Medicine) Physician

An internist who diagnoses, treats and supports patients with multiple organ dysfunction. This specialist may have administrative responsibilities for intensive care units and may also facilitate and coordinate patient care among the primary physician, the critical care staff and other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Endocrinology, Diabetes & Metabolism

207RE0101X Endocrinology, Diabetes & Metabolism Physician

An internist who concentrates on disorders of the internal (endocrine) glands such as the thyroid and adrenal glands. This specialist also deals with disorders such as diabetes, metabolic and nutritional disorders, obesity, pituitary diseases and menstrual and sexual problems.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Gastroenterology

207RG0100X Gastroenterology Physician

An internist who specializes in diagnosis and treatment of diseases of the digestive organs including the stomach, bowels, liver and gallbladder. This specialist treats conditions such as abdominal pain, ulcers, diarrhea, cancer and jaundice and performs complex diagnostic and therapeutic procedures using endoscopes to visualize internal organs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Geriatric Medicine

207RG0300X Geriatric Medicine (Internal Medicine) Physician

An internist who has special knowledge of the aging process and special skills in the diagnostic, therapeutic, preventive and rehabilitative aspects of illness in the elderly. This specialist cares for geriatric patients in the patient's home, the office, long-term care settings such as nursing homes and the hospital.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Hematology

207RH0000X Hematology (Internal Medicine) Physician

An internist with additional training who specializes in diseases of the blood, spleen and lymph. This specialist treats conditions such as anemia, clotting disorders, sickle cell disease, hemophilia, leukemia and lymphoma.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Hematology & Oncology

207RH0003X Hematology & Oncology Physician

An internist doctor of osteopathy that specializes in the treatment of the combination of hematology and oncology disorders. A doctor of osteopathy that is board eligible/certified by the American Osteopathic Board of Internal Medicine WAS able to obtain a Certificate of Special Qualifications in the field of Hematology and Oncology. The Certificate is NO longer offered.

Source: American Osteopathic Board of Internal Medicine, 2007. [7/1/2008: definition added, source added; 7/1/2011: modified source]

Additional Resources: http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Hepatology

207RI0008X Hepatology Physician

The discipline of Hepatology encompasses the structure, function, and diseases of the liver and biliary tract. The American Board of Internal Medicine considers Hepatology part of the subspecialty of gastroenterology. Physicians who identify themselves as Hepatologists usually, but not always, have been trained in gastrointestinal programs.

Training Programs, and/or Fellowships, Preceptorships: The American Association for the Study of Liver Diseases (AASLD) is the major professional society organized for physicians with an interest in Hepatology. A subcommittee of that organization has published guidelines for training programs in the 1992 November issue of Hepatology. Source: The American Board of Internal Medicine 9/1993 ACGME Accredited Residency Program Requirements: None

Effective Date 4/1/2003

Specialization: Hospice and Palliative Medicine

207RH0002X Hospice and Palliative Medicine (Internal Medicine) Physician

An internal medicine physician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Hypertension Specialist

207RH0005X Hypertension Specialist Physician

A Hypertension Specialist is a physician who concentrates on all aspects of the diagnosis and treatment of hypertension.

Source: American Society of Hypertension, www.ash-us.org [7/1/2011: new] Additional Resources: The American Society of Hypertension Specialists Program offers an examination and designation for Hypertension Specialists. This subspecialty is not a Board certificate issued by either the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

Effective Date 10/1/201

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Infectious Disease

207RI0200X Infectious Disease Physician

An internist who deals with infectious diseases of all types and in all organ systems. Conditions requiring selective use of antibiotics call for this special skill. This physician often diagnoses and treats AIDS patients and patients with fevers which have not been explained. Infectious disease specialists may also have expertise in preventive medicine and travel medicine.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Interventional Cardiology

207RI0011X Interventional Cardiology Physician

An area of medicine within the subspecialty of cardiology, which uses specialized imaging and other diagnostic techniques to evaluate blood flow and pressure in the coronary arteries and chambers of the heart and uses technical procedures and medications to treat abnormalities that impair the function of the cardiovascular system.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/ Board Certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. ACGME Accredited Residency Program Requirements: 1 year of training plus a prerequisite of 3 years Internal Medicine, 3 years Cardiovascular Disease for a total of 7 years. ABMS Approved Subspecialty Certificate (Internal Medicine)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Magnetic Resonance Imaging (MRI)

207RM1200X Magnetic Resonance Imaging (MRI) Internal Medicine Physician

Definition to come.

Effective Date 4/1/2003

Specialization: Medical Oncology

207RX0202X Medical Oncology Physician

An internist who specializes in the diagnosis and treatment of all types of cancer and other benign and malignant tumors. This specialist decides on and administers therapy for these malignancies as well as consults with surgeons and radiotherapists on other treatments for cancer.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source. 11/5/2007: corrected definition]

Effective Date 4/1/2003 Last Modified Date 11/5/2007

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Nephrology

207RN0300X Nephrology Physician

An internist who treats disorders of the kidney, high blood pressure, fluid and mineral balance and dialysis of body wastes when the kidneys do not function. This specialist consults with surgeons about kidney transplantation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Obesity Medicine

207RB0002X Obesity Medicine (Internal Medicine) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [10/1/2007: new, 7/1/2015: title and definition modified] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/200

Specialization: Pulmonary Disease

207RP1001X Pulmonary Disease Physician

An internist who treats diseases of the lungs and airways. The pulmonologist diagnoses and treats cancer, pneumonia, pleurisy, asthma, occupational and environmental diseases, bronchitis, sleep disorders, emphysema and other complex disorders of the lungs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Rheumatology

207RR0500X Rheumatology Physician

An internist who treats diseases of joints, muscle, bones and tendons. This specialist diagnoses and treats arthritis, back pain, muscle strains, common athletic injuries and "collagen" diseases.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Sleep Medicine

207RS0012X Sleep Medicine (Internal Medicine) Physician

An Internist who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, www.aasm.org [7/1/2006: new]

Effective Date 10/1/200

Specialization: Sports Medicine

207RS0010X Sports Medicine (Internal Medicine) Physician

An internist trained to be responsible for continuous care in the field of sports medicine, not only for the enhancement of health and fitness, but also for the prevention of injury and illness. A sports medicine physician must have knowledge and experience in the promotion of wellness and the prevention of injury. Knowledge about special areas of medicine such as exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation, epidemiology, physical evaluation, injuries (treatment and prevention and referral practice) and the role of exercise in promoting a healthy lifestyle are essential to the practice of sports medicine. The sports medicine physician requires special education to provide the knowledge to improve the healthcare of the individual.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Transplant Hepatology

207RT0003X Transplant Hepatology Physician

An internist with special knowledge and the skill required of a gastroenterologist to care for patients prior to and following hepatic transplantation that spans all phases of liver transplantation. Selection of appropriate recipients requires assessment by a team having experience in evaluating the severity and prognosis of patients with liver disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new] Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine.

Effective Date 10/1/200

Legal Medicine

209800000X Legal Medicine (M.D./D.O.) Physician

Legal Medicine is a special field of medicine that focuses on various aspects of medicine and law. Historically, the practice of legal medicine made contributions to medicine as a scientific instrument to solve criminal perplexities. Since World War II, the domain of legal medicine has broadened to include not only aspects of medical science to solve legal and criminal problems but aspects of law as it applies to medicine. Legal Medicine continues to grow as medicolegal issues like medical malpractice and liability, government regulation of health care, issues of tort reform, and moral and ethical complexities presented by technological advances become increasingly prominent. Many medical schools have implemented courses which supply medicolegal instruction for medical students, and many law schools now offer medicolegal courses. Also, dual degree programs in law and medicine have been created to assist physicians to bridge the gap between medicine and the law.

Source: American Board of Legal Medicine 08/1992. www.ablminc.org [7/1/2009: definition reformatted] Additional Resources: Training Programs, and/or Fellowships, Preceptorships: Certification available through the American Board of Legal Medicine. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003

Medical Genetics

Specialization: Clinical Biochemical Genetics

207SG0202X Clinical Biochemical Genetics Physician

A clinical biochemical geneticist demonstrates competence in performing and interpreting biochemical analyses relevant to the diagnosis and management of human genetic diseases and is a consultant regarding laboratory diagnosis of a broad range of inherited disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Medical Genetics

Specialization: Clinical Cytogenetics

207SC0300X Clinical Cytogenetics Physician

A clinical cytogeneticist demonstrates competence in providing laboratory diagnostic and clinical interpretive services dealing with cellular components, particularly chromosomes, associated with heredity.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics. A general certificate was first issued by the ABMS in 1982. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Clinical Genetics (M.D.)

207SG0201X Clinical Genetics (M.D.) Physician

A clinical geneticist demonstrates competence in providing comprehensive diagnostic, management and counseling services for genetic disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Clinical Molecular Genetics

207SG0203X Clinical Molecular Genetics Physician

A clinical molecular geneticist demonstrates competence in performing and interpreting molecular analyses relevant to the diagnosis and management of human genetic diseases and is a consultant regarding laboratory diagnosis of a broad range of inherited disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Molecular Genetic Pathology

207SM0001X Molecular Genetic Pathology (Medical Genetics) Physician

A board certified subspecialty, the molecular genetic pathologist is expert in the principles, theory and technologies of molecular biology and molecular genetics. This expertise is used to make or confirm diagnoses of Mendelian genetic disorders, of human development, infectious diseases and malignancies and to assess the natural history of those disorders. A molecular genetic pathologist provides information about gene structure, function and alteration, and applies laboratory techniques for diagnosis, treatment and prognosis for individuals with related disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics. A subspecialty certificate for MGG was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Proposal under development.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Medical Genetics

Specialization: Ph.D. Medical Genetics

207SG0205X Ph.D. Medical Genetics Physician

A medical geneticist works in association with a medical specialist, is affiliated with a clinical genetics program and serves as a consultant to medical and dental specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Neurological Surgery

207T00000X Neurological Surgery Physician

A neurological surgeon provides the operative and non-operative management (i.e., prevention, diagnosis, evaluation, treatment, critical care, and rehabilitation) of disorders of the central, peripheral, and autonomic nervous systems, including their supporting structures and vascular supply; the evaluation and treatment of pathological processes which modify function or activity of the nervous system; and the operative and non-operative management of pain. A neurological surgeon treats patients with disorders of the nervous system; disorders of the brain, meninges, skull, and their blood supply, including the extracranial carotid and vertebral arteries; disorders of the pituitary gland; disorders of the spinal cord, meninges, and vertebral column, including those which may require treatment by spinal fusion or instrumentation; and disorders of the cranial and spinal nerves throughout their distribution.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Neurological Surgery, 2007. http://www.abns.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Neurological Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Neuromusculoskeletal Medicine & OMM

204D00000X Neuromusculoskeletal Medicine & OMM Physician

The Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine physician directs special attention to the neuromusculoskeletal system and its interaction with other body systems. Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine encompasses increased knowledge and understanding of osteopathic principles and practice and heightened technical skills of osteopathic manipulative medicine, and integrates each of these into the management of pediatric, adolescent, adult, and geriatric patients.

Source: American Osteopathic Association, 2017 [7/1/2017: added definition]

Additional Resources: American Osteopathic Board of Neuromusculoskeletal Medicine, 2017, http://www.osteopathic.org/certification

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Neuromusculoskeletal Medicine, Sports Medicine

204C00000X Sports Medicine (Neuromusculoskeletal Medicine) Physician

Definition to come.

Effective Date 4/1/2003

Nuclear Medicine

207U00000X Nuclear Medicine Physician

A nuclear medicine specialist employs the properties of radioactive atoms and molecules in the diagnosis and treatment of disease and in research. Radiation detection and imaging instrument systems are used to detect disease as it changes the function and metabolism of normal cells, tissues and organs. A wide variety of diseases can be found in this way, usually before the structure of the organ involved by the disease can be seen to be abnormal by any other techniques. Early detection of coronary artery disease (including acute heart attack), early cancer detection and evaluation of the effect of tumor treatment, diagnosis of infection and inflammation anywhere in the body and early detection of blood clot in the lungs are all possible with these techniques. Unique forms of radioactive molecules can attack and kill cancer cells (e.g., lymphoma, thyroid cancer) or can relieve the severe pain of cancer that has spread to bone

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Nuclear Medicine, 2007. http://www.abnm.org/. A doctor of osteopathy was able to obtain a Certificate of Added Qualifications in the field of Nuclear Medicine. The Certificate is NO longer offered.

American Osteopathic Board of Nuclear Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Nuclear Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: In Vivo & In Vitro Nuclear Medicine

207UN0903X In Vivo & In Vitro Nuclear Medicine Physician

A nuclear medicine physician who specializes in in vivo and in vitro nuclear medicine.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Nuclear Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Nuclear Cardiology

207UN0901X Nuclear Cardiology Physician

A nuclear medicine physician who specializes in nuclear cardiology.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Nuclear Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Allopathic & Osteopathic Physicians

Nuclear Medicine

Specialization: Nuclear Imaging & Therapy

207UN0902X Nuclear Imaging & Therapy Physician

A nuclear medicine physician who specializes in nuclear imaging and therapy.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Nuclear Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Obstetrics & Gynecology

207V00000X Obstetrics & Gynecology Physician

An obstetrician/gynecologist possesses special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders. This physician serves as a consultant to other physicians and as a primary physician for women.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Critical Care Medicine

207VC0200X Critical Care Medicine (Obstetrics & Gynecology) Physician

An obstetrician/gynecologist, who specializes in critical care medicine diagnoses, treats and supports female patients with multiple organ dysfunction. This specialist may have administrative responsibilities for intensive care units and may also facilitate and coordinate patient care among the primary physician, the critical care staff and other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Obstetrics & Gynecology

Specialization: Female Pelvic Medicine and Reconstructive Surgery

207VF0040X Female Pelvic Medicine and Reconstructive Surgery (Obstetrics & Gynecology) Ph

A subspecialist in Female Pelvic Medicine and Reconstructive Surgery is a physician in Urology or Obstetrics and Gynecology who, by virtue of education and training, is prepared to provide consultation and comprehensive management of women with complex benign pelvic conditions, lower urinary tract disorders, and pelvic floor dysfunction. Comprehensive management includes those diagnostic and therapeutic procedures necessary for the total care of the patient with these conditions and complications resulting from them.

Source: American Board of Medical Specialties, 2011. [1/1/2012: new] Resources: www.abms.org

Effective Date 4/1/2012

Specialization: Gynecologic Oncology

207VX0201X Gynecologic Oncology Physician

An obstetrician/gynecologist who provides consultation and comprehensive management of patients with gynecologic cancer, including those diagnostic and therapeutic procedures necessary for the total care of the patient with gynecologic cancer and resulting complications.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Gynecology

207VG0400X Gynecology Physician

Definition to come...

Effective Date 4/1/2003

Specialization: Hospice and Palliative Medicine

207VH0002X Hospice and Palliative Medicine (Obstetrics & Gynecology) Physician

An obstetrician/gynecologist with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Obstetrics & Gynecology

Specialization: Maternal & Fetal Medicine

207VM0101X Maternal & Fetal Medicine Physician

An obstetrician/gynecologist who cares for, or provides consultation on, patients with complications of pregnancy. This specialist has advanced knowledge of the obstetrical, medical and surgical complications of pregnancy and their effect on both the mother and the fetus. The specialist also possesses expertise in the most current diagnostic and treatment modalities used in the care of patients with complicated pregnancies.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Obesity Medicine

207VB0002X Obesity Medicine (Obstetrics & Gynecology) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [10/1/2007: new, 7/1/2015: title and definition modified] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/200

Specialization: Obstetrics

207VX0000X Obstetrics Physician

Definition to come...

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Obstetrics & Gynecology

Specialization: Reproductive Endocrinology

207VE0102X Reproductive Endocrinology Physician

An obstetrician/gynecologist who is capable of managing complex problems relating to reproductive endocrinology and infertility.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Ophthalmology

207W00000X Ophthalmology Physician

An ophthalmologist has the knowledge and professional skills needed to provide comprehensive eye and vision care. Ophthalmologists are medically trained to diagnose, monitor and medically or surgically treat all ocular and visual disorders. This includes problems affecting the eye and its component structures, the eyelids, the orbit and the visual pathways. In so doing, an ophthalmologist prescribes vision services, including glasses and contact lenses.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Ophthalmology, 2007. http://www.abop.org/. American Osteopathic Board of Ophthalmology and Otolaryngology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Ophthalmology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Cornea and External Diseases Specialist

207WX0120X Cornea and External Diseases Specialist Physician

An ophthalmologist who specializes in diseases of the cornea, sclera, eyelids, conjunctiva, and anterior segment of the eye.

Source: American Academy of Ophthalmology, www.aao.org [1/1/2018: new]

Effective Date 4/1/2018

Allopathic & Osteopathic Physicians

Ophthalmology

Specialization: Glaucoma Specialist

207WX0009X Glaucoma Specialist (Ophthalmology) Physician

An ophthalmologist who specializes in the treatment of glaucoma and other disorders related to increased intraocular pressure and optic nerve damage. This specialty involves the medical and surgical treatment of these conditions.

Source: American Academy of Ophthalmology, www.aao.org [1/1/2017: new] Additional Resources: Association of University Professors of Ophthalmology, www.aupo.org

Effective Date 4/1/2017

Specialization: Neuro-ophthalmology

207WX0109X Neuro-ophthalmology Physician

A neuro-ophthalmologist is a subspecialist of ophthalmology. This physician evaluates, treats, and studies disorders of the eye, orbit and nervous system having to do with interactions of the visual motor and visual sensory systems with the central nervous system. Neuro-ophthalmologists manage patients with complex and severe neuro-ophthalmological disorders.

Source: American Academy of Ophthalmology, www.aao.org [7/1/2017: new]

Additional Resources: Association of University Professors of Ophthalmology, www.aupo.org.

Effective Date 10/1/201

Specialization: Ophthalmic Plastic and Reconstructive Surgery

207WX0200X Ophthalmic Plastic and Reconstructive Surgery Physician

A physician who specializes in oculofacial plastic and reconstructive surgery. This subspecialty combines orbital and periocular surgery with facial plastic surgery, and includes aesthetic and reconstructive surgery of the face, orbit, eyelid, and lacrimal system. Practitioners evaluate, diagnose and treat conditions involving the eyelids, brows, midface, orbits, lacrimal systems and surrounding and supporting structures of the face and neck.

Source: American Academy of Ophthalmology, 2015. www.aao.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: Pediatric Ophthalmology and Strabismus Specialist

207WX0110X Pediatric Ophthalmology and Strabismus Specialist Physician Physician

An ophthalmologist who specializes in pediatric ophthalmology and strabismus management. The subspecialty includes the medical and surgical management of eye disorders found in children. Some of the more common disorders include amblyopia, strabismus, refractive error, cataract and glaucoma. These disorders may be related to neurological and endocrinological diseases, trauma, or aging changes in the extraocular muscles requiring medical, optical and surgical management.

Source: American Academy of Ophthalmology, www.aao.org [7/1/2017: new]

Additional Resources: Association of University Professors of Ophthalmology, www.aupo.org.

Effective Date 10/1/201

Allopathic & Osteopathic Physicians

Ophthalmology

Specialization: Retina Specialist

207WX0107X Retina Specialist (Ophthalmology) Physician

An ophthalmologist who specializes in the diagnosis and treatment of vitreoretinal diseases.

Source: American Society of Retina Specialists, www.asrs.org [1/1/2017: new]

Additional Resources: American Academy of Ophthalmology, www.aao.org. Macula Society, www.maculasociety.org. Retina Society, www.retinasociety.org. Association of University Professors of Ophthalmology, www.aupo.org.

Effective Date 4/1/2017

Specialization: Uveitis and Ocular Inflammatory Disease

207WX0108X Uveitis and Ocular Inflammatory Disease (Ophthalmology) Physician

An ophthalmologist who specializes in the treatment of intraocular inflammation, scleritis, keratitis and infectious disorders affecting the eye and inflammatory disorders of the adnexa and/or orbit.

Source: American Academy of Ophthalmology, www.aao.org [1/1/2017: new]

Additional Resources: Association of University Professors of Ophthalmology, www.aupo.org

Effective Date 4/1/2017

Oral & Maxillofacial Surgery

204E00000X Oral & Maxillofacial Surgery (D.M.D.)

Oral and maxillofacial surgeons are trained to recognize and treat a wide spectrum of diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the oral and maxillofacial region. They are also trained to administer anesthesia, and provide care in an office setting. They are trained to treat problems such as the extraction of wisdom teeth, misaligned jaws, tumors and cysts of the jaw and mouth, and to perform dental implant surgery.

Source: American College of Surgeons, 2013. www.facs.org [7/1/2013: definition added, source added, additional resources added] Additional Resources: American Board of Oral and Maxillofacial Surgery and American Association of Oral and Maxillofacial Surgeons While this is generally considered a specialty of dentistry, physicians can also be board certified as oral and maxillofacial surgeons through the American Board of Oral and Maxillofacial Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2013

Allopathic & Osteopathic Physicians

Orthopaedic Surgery

207X00000X Orthopaedic Surgery Physician

An orthopaedic surgeon is trained in the preservation, investigation and restoration of the form and function of the extremities, spine and associated structures by medical, surgical and physical means. An orthopaedic surgeon is involved with the care of patients whose musculoskeletal problems include congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries and degenerative diseases of the spine, hands, feet, knee, hip, shoulder and elbow in children and adults. An orthopaedic surgeon is also concerned with primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. American Osteopathic Board of Orthopaedic Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Orthopaedic Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Orthopaedic Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Adult Reconstructive Orthopaedic Surgery

207XS0114X Adult Reconstructive Orthopaedic Surgery Physician

Recognized by several state medical boards as a fellowship subspecialty program of orthopaedic surgery, adult reconstructive orthopaedic surgeons deal with reconstructive procedures such as joint arthroplasty (i.e., hip and knee), osteotomy, arthroscopy, soft-tissue reconstruction, and a variety of other adult reconstructive surgical procedures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Separate board certification is not currently offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Foot and Ankle Surgery

207XX0004X Orthopaedic Foot and Ankle Surgery Physician

Recognized by several state medical boards as a fellowship subspecialty program of orthopaedic surgery, foot and ankle surgeons deal with adult reconstructive foot and ankle surgery, adult foot and ankle trauma, sports medicine foot and ankle, and children's foot and ankle reconstructive surgery.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: title modified, definition added, source added] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Separate board certification is not currently offered. ACGME Accredited Residency Program Requirements: 1 year of training with 5 years Orthopedic Surgery for a total of 6 years.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Orthopaedic Surgery

Specialization: Hand Surgery

207XS0106X Orthopaedic Hand Surgery Physician

An orthopaedic surgeon trained in the investigation, preservation and restoration by medical, surgical and rehabilitative means of all structures of the upper extremity directly affecting the form and function of the hand and wrist.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. American Osteopathic Board of Orthopaedic Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Orthopaedic Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Orthopaedic Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Orthopaedic Surgery of the Spine

207XS0117X Orthopaedic Surgery of the Spine Physician

Recognized by several state medical boards as a fellowship subspecialty program of orthopaedic surgery, orthopaedic surgeons of the spine deal with the evaluation and nonoperative and operative treatment of the full spectrum of primary spinal disorders including trauma, degenerative, deformity, tumor, and reconstructive.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Separate board certification is not currently offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Orthopaedic Trauma

207XX0801X Orthopaedic Trauma Physician

Recognized by several state medical boards as a fellowship subspecialty program of orthopaedic surgery, orthopaedic trauma surgeons deal with the evaluation and management of acute orthopaedic injuries, evaluation and treatment of post-traumatic deformities and nonunions, acute and delayed reconstruction of pelvic and acetabular fractures, as well as osteotomy in the adult hip for treatment of hip arthritis.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Separate board certification is not currently offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Orthopaedic Surgery

207XP3100X Pediatric Orthopaedic Surgery Physician

An orthopedic surgeon who has additional training and experience in diagnosing, treating and managing musculoskeletal problems in infants, children and adolescents. These may include limb and spine deformities (such as club foot, scoliosis); gait abnormalities (limping); bone and joint infections; broken bones.

Source: American Academy of Pediatrics, www.aap.org [7/1/2006: new]

Effective Date 10/1/200

Allopathic & Osteopathic Physicians

Orthopaedic Surgery

Specialization: Sports Medicine

207XX0005X Sports Medicine (Orthopaedic Surgery) Physician

An orthopaedic surgeon trained in sports medicine provides appropriate care for all structures of the musculoskeletal system directly affected by participation in sporting activity. This specialist is proficient in areas including conditioning, training and fitness, athletic performance and the impact of dietary supplements, pharmaceuticals, and nutrition on performance and health, coordination of care within the team setting utilizing other health care professionals, field evaluation and management, soft tissue biomechanics and injury healing and repair. Knowledge and understanding of the principles and techniques of rehabilitation, athletic equipment and orthotic devices enables the specialist to prevent and manage athletic injuries.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Orthopaedic Surgery. ACGME Accredited Program Requirements: 1 year GME in the specialty + 5 years of Orthopaedic Surgery for a total of 6 years

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Otolaryngology

207Y00000X Otolaryngology Physician

An otolaryngologist-head and neck surgeon provides comprehensive medical and surgical care for patients with diseases and disorders that affect the ears, nose, throat, the respiratory and upper alimentary systems and related structures of the head and neck. An otolaryngologist diagnoses and provides medical and/or surgical therapy or prevention of diseases, allergies, neoplasms, deformities, disorders and/or injuries of the ears, nose, sinuses, throat, respiratory and upper alimentary systems, face, jaws and the other head and neck systems. Head and neck oncology, facial plastic and reconstructive surgery and the treatment of disorders of hearing and voice are fundamental areas of expertise.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Otolaryngology, 2007. http://www.aboto.org/. American Osteopathic Board of Ophthalmology and Otolaryngology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Otolaryngology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Facial Plastic Surgery

207YS0123X Facial Plastic Surgery Physician

An otolaryngologist who specializes in facial plastic surgery.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A General Certificate was, but is no longer issued by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Allopathic & Osteopathic Physicians

Otolaryngology

Specialization: Otolaryngic Allergy

207YX0602X Otolaryngic Allergy Physician

An otolaryngologist who specializes in the diagnosis and treatment of otolaryngic allergies and other allergic diseases.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) is issued by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Otolaryngology/Facial Plastic Surgery

207YX0905X Otolaryngology/Facial Plastic Surgery Physician

An otolaryngologist who specializes in the diagnosis and surgical treatment of head and neck conditions.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A General Certificate is issued by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Otology & Neurotology

207YX0901X Otology & Neurotology Physician

An otolaryngologist who treats diseases of the ear and temporal bone, including disorders of hearing and balance. The additional training in otology and neurotology emphasizes the study of embryology, anatomy, physiology, epidemiology, pathophysiology, pathology, genetics, immunology, microbiology and the etiology of diseases of the ear and temporal bone.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Otolaryngology, 2007. http://www.aboto.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Otolaryngology

207YP0228X Pediatric Otolaryngology Physician

A pediatric otolaryngologist has special expertise in the management of infants and children with disorders that include congenital and acquired conditions involving the aerodigestive tract, nose and paranasal sinuses, the ear and other areas of the head and neck. The pediatric otolaryngologist has special skills in the diagnosis, treatment, and management of childhood disorders of voice, speech, language and hearing.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Otolaryngology, 2007. http://www.aboto.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Otolaryngology

Specialization: Plastic Surgery within the Head & Neck

207YX0007X Plastic Surgery within the Head & Neck (Otolaryngology) Physician

An otolaryngologist with additional training in plastic and reconstructive procedures within the head, face, neck and associated structures, including cutaneous head and neck oncology and reconstruction, management of maxillofacial trauma, soft tissue repair and neural surgery. The field is diverse and involves a wide age range of patients, from the newborn to the aged. While both cosmetic and reconstructive surgeries are practiced, there are many additional procedures which interface with them.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Otolaryngology, 2007. http://www.aboto.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Otolaryngology. Board certification for Doctors of Osteopathy is currently provided in the subspecialty of Otolaryngology/Facial Plastic Surgery (see Taxonomy Code 207YX0905X)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Sleep Medicine

207YS0012X Sleep Medicine (Otolaryngology) Physician

An Otolaryngologist who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, www.aasm.org [7/1/2006: new]

Effective Date 10/1/200

Pain Medicine

Specialization: Interventional Pain Medicine

208VP0014X Interventional Pain Medicine Physician

Interventional Pain Medicine is the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders principally with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment.

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Pain Medicine

Specialization: Pain Medicine

208VP0000X Pain Medicine Physician

Pain Medicine is a primary medical specialty based on a distinct body of knowledge and a well-defined scope of clinical practice that is founded on science, research and education. It is concerned with the study of pain, the prevention of pain, and the evaluation, treatment, and rehabilitation of persons in pain. A comprehensive evaluation incorporates the physical, psychological, cognitive and socio-cultural contributions to pain. The treatment protocol may include pharmacological, invasive, behavioral, cognitive, rehabilitative and complementary strategies provided in a concurrent focused and patient specific manner. The pain medicine physician often serves the patient as a frontline physician regarding their pain, but also may serve as a consultant to other physicians, direct an interdisciplinary/multidisciplinary treatment team, conduct research, or advocate for the patient's pain care with public and private agencies. The Pain Medicine physician may work in variety of settings including office, clinic, hospital, university, or governmental/public agencies.

Source: American Academy of Pain Medicine, www.painmed.org

Additional Resources: The American Board of Pain Medicine provides Board Certification.

Effective Date 4/1/2003

Pathology

Specialization: Anatomic Pathology

207ZP0101X Anatomic Pathology Physician

A pathologist deals with the causes and nature of disease and contributes to diagnosis, prognosis and treatment through knowledge gained by the laboratory application of the biologic, chemical and physical sciences. A pathologist uses information gathered from the microscopic examination of tissue specimens, cells and body fluids, and from clinical laboratory tests on body fluids and secretions for the diagnosis, exclusion and monitoring of disease.

Source: American Board of Medical Specialties, 2007. [7/1/2007: definition added, source added, 7/1/2009: definition reformatted; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology (note: this taxonomy code identifies the "anatomic pathology only" route). To acknowledge the diverse activities in the practice of pathology and to accommodate the interests of individuals wanting to enter the field, the ABP offers primary certification through the following three routes: combined anatomic pathology and clinical pathology, anatomic pathology only and clinical pathology only. Primary certification in anatomic pathology or clinical pathology may be combined with some of the subspecialty certifications.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pathology

Specialization: Anatomic Pathology & Clinical Pathology

207ZP0102X Anatomic Pathology & Clinical Pathology Physician

A pathologist deals with the causes and nature of disease and contributes to diagnosis, prognosis and treatment through knowledge gained by the laboratory application of the biologic, chemical and physical sciences. A pathologist uses information gathered from the microscopic examination of tissue specimens, cells and body fluids, and from clinical laboratory tests on body fluids and secretions for the diagnosis, exclusion and monitoring of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added, 7/1/2009: definition reformatted] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/ This taxonomy code identifies the combined anatomic pathology & clinical pathology route. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. To acknowledge the diverse activities in the practice of pathology and to accommodate the interests of individuals wanting to enter the field, the ABP offers primary certification through the following three routes: combined anatomic pathology and clinical pathology, anatomic pathology only and clinical pathology only. Primary certification in anatomic pathology or clinical pathology may be combined with some of the subspecialty certifications.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Blood Banking & Transfusion Medicine

207ZB0001X Blood Banking & Transfusion Medicine Physician

A physician who specializes in blood banking/transfusion medicine is responsible for the maintenance of an adequate blood supply, blood donor and patient-recipient safety and appropriate blood utilization. Pre-transfusion compatibility testing and antibody testing assure that blood transfusions, when indicated, are as safe as possible. This physician directs the preparation and safe use of specially prepared blood components, including red blood cells, white blood cells, platelets and plasma constituents, and marrow or stem cells for transplantation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pathology

Specialization: Chemical Pathology

207ZP0104X Chemical Pathology Physician

A chemical pathologist has expertise in the biochemistry of the human body as it applies to the understanding of the cause and progress of disease. This physician functions as a clinical consultant in the diagnosis and treatment of human disease. Chemical pathology entails the application of biochemical data to the detection, confirmation or monitoring of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Clinical Informatics

207ZC0008X Clinical Informatics (Pathology) Physician

Physicians who practice Clinical Informatics collaborate with other health care and information technology professionals to analyze, design, implement and evaluate information and communication systems that enhance individual and population health outcomes, improve patient care, and strengthen the clinician-patient relationship. Clinical Informaticians use their knowledge of patient care combined with their understanding of informatics concepts, methods, and tools to: assess information and knowledge needs of health care professionals and patients; characterize, evaluate, and refine clinical processes; develop, implement, and refine clinical decision support systems; and lead or participate in the procurement, customization, development, implementation, management, evaluation, and continuous improvement of clinical information systems.

Source: The American Board of Preventive Medicine, 2013. www.theabpm.org [1/1/2014: new] Additional Resources: The American Board of Pathology, www.abpath.org

Effective Date 4/1/2014

Allopathic & Osteopathic Physicians

Pathology

Specialization: Clinical Pathology

207ZC0006X Clinical Pathology Physician

A pathologist deals with the causes and nature of disease and contributes to diagnosis, prognosis and treatment through knowledge gained by the laboratory application of the biologic, chemical and physical sciences. A pathologist uses information gathered from the microscopic examination of tissue specimens, cells and body fluids, and from clinical laboratory tests on body fluids and secretions for the diagnosis, exclusion and monitoring of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new, 7/1/2009: definition reformatted] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/ This taxonomy code identifies the combined anatomic "clinical pathology only" route. Board Certification for Medical Doctors (MDs) is provided by the American Board of Pathology. To acknowledge the diverse activities in the practice of pathology and to accommodate the interests of individuals wanting to enter the field, the ABP offers primary certification through the following three routes: combined anatomic pathology and clinical pathology, anatomic pathology only and clinical pathology only. Primary certification in anatomic pathology or clinical pathology may be combined with some of the subspecialty certifications.

Effective Date 10/1/200

Specialization: Clinical Pathology/Laboratory Medicine

207ZP0105X Clinical Pathology/Laboratory Medicine Physician

A pathologist deals with the causes and nature of disease and contributes to diagnosis, prognosis and treatment through knowledge gained by the laboratory application of the biologic, chemical and physical sciences. A pathologist uses information gathered from the microscopic examination of tissue specimens, cells and body fluids, and from clinical laboratory tests on body fluids and secretions for the diagnosis, exclusion and monitoring of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Cytopathology

207ZC0500X Cytopathology Physician

A cytopathologist is an anatomic pathologist trained in the diagnosis of human disease by means of the study of cells obtained from body secretions and fluids, by scraping, washing, or sponging the surface of a lesion, or by the aspiration of a tumor mass or body organ with a fine needle. A major aspect of a cytopathologist's practice is the interpretation of Papanicolaou-stained smears of cells from the female reproductive systems, the "Pap" test. However, the cytopathologist's expertise is applied to the diagnosis of cells from all systems and areas of the body. He/she is a consultant to all medical specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Pathology

Specialization: Dermatopathology

207ZD0900X Dermatopathology (Pathology) Physician

A dermatopathologist is an expert in diagnosing and monitoring diseases of the skin including infectious, immunologic, degenerative, and neoplastic diseases. This entails the examination and interpretation of specially prepared tissue sections, cellular scrapings, and smears of skin lesions by means of light microscopy, electron microscopy, and fluorescence microscopy.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. A subspecialty certificate was first issued by the ABMS in 1974. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Forensic Pathology

207ZF0201X Forensic Pathology Physician

A forensic pathologist is expert in investigating and evaluating cases of sudden, unexpected, suspicious and violent death as well as other specific classes of death defined by law. The forensic pathologist serves the public as coroner or medical examiner, or by performing medicolegal autopsies for such officials.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Hematology

207ZH0000X Hematology (Pathology) Physician

A hematopathologist is expert in diseases that affect blood cells, blood clotting mechanisms, bone marrow and lymph nodes. This physician has the knowledge and technical skills essential for the laboratory diagnosis of anemias, leukemias, lymphomas, bleeding disorders and blood clotting disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pathology

Specialization: Immunopathology

207ZI0100X Immunopathology Physician

A pathologist who specializes in the diagnosis of immunologic diseases.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Pathology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Medical Microbiology

207ZM0300X Medical Microbiology Physician

A medical microbiologist is expert in the isolation and identification of microbial agents that cause infectious disease. Viruses, bacteria and fungi, as well as parasites, are identified and, where possible, tested for susceptibility to appropriate antimicrobial agents.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Molecular Genetic Pathology

207ZP0007X Molecular Genetic Pathology (Pathology) Physician

A molecular genetic pathologist is expert in the principles, theory and technologies of molecular biology and molecular genetics. This expertise is used to make or confirm diagnoses of Mendelian genetic disorders, disorders of human development, infectious diseases and malignancies, and to assess the natural history of those disorders. A molecular genetic pathologist provides information about gene structure, function and alteration and applies laboratory techniques for diagnosis, treatment and prognosis for individuals with related disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. A subspecialty certificate for MGG was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Proposal under development.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Pathology

Specialization: Neuropathology

207ZN0500X Neuropathology Physician

A neuropathologist is expert in the diagnosis of diseases of the nervous system and skeletal muscles and functions as a consultant primarily to neurologists and neurosurgeons. The neuropathologist is knowledgeable in the infirmities of humans as they affect the nervous and neuromuscular systems, be they degenerative, infectious, metabolic, immunologic, neoplastic, vascular or physical in nature.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Pathology

207ZP0213X Pediatric Pathology Physician

A pediatric pathologist is expert in the laboratory diagnosis of diseases that occur during fetal growth, infancy and child development. The practice requires a strong foundation in general pathology and substantial understanding of normal growth and development, along with extensive knowledge of pediatric medicine.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Pediatrics

208000000X Pediatrics Physician

A pediatrician is concerned with the physical, emotional and social health of children from birth to young adulthood. Care encompasses a broad spectrum of health services ranging from preventive healthcare to the diagnosis and treatment of acute and chronic diseases. A pediatrician deals with biological, social and environmental influences on the developing child, and with the impact of disease and dysfunction on development.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certificatio

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Adolescent Medicine

2080A0000X Pediatric Adolescent Medicine Physician

A pediatrician who specializes in adolescent medicine is a multi-disciplinary healthcare specialist trained in the unique physical, psychological and social characteristics of adolescents, their healthcare problems and needs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Child Abuse Pediatrics

2080C0008X Child Abuse Pediatrics Physician

A Child Abuse Pediatrician serves as a resource to children, families and communities by accurately diagnosing abuse; consulting with community agencies on child safety; providing expertise in courts of law; treating consequences of abuse and neglect; directing child abuse and neglect prevention programs and participating on multidisciplinary teams investigating; and managing child abuse cases.

Source: American Board of Medical Specialties, 2009 [7/1/2009: new]

Effective Date 10/1/200

Specialization: Clinical & Laboratory Immunology

2080I0007X Pediatric Clinical & Laboratory Immunology Physician

A pediatrician who specializes in clinical and laboratory immunology disease management.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A certification was, but is no longer issued by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Developmental - Behavioral Pediatrics

2080P0006X Developmental - Behavioral Pediatrics Physician

A developmental-behavioral specialist is a pediatrician with special training and experience who aims to foster understanding and promotion of optimal development of children and families through research, education, clinical care and advocacy efforts. This physician assists in the prevention, diagnosis, and management of developmental difficulties and problematic behaviors in children and in the family dysfunctions that compromise children's development.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed, 3/26/2008: definition corrected] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Hospice and Palliative Medicine

2080H0002X Pediatric Hospice and Palliative Medicine Physician

A pediatrician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Medical Toxicology

2080T0002X Pediatric Medical Toxicology Physician

Medical toxicologists are physicians that specialize in the prevention, evaluation, treatment and monitoring of injury and illness from exposures to drugs and chemicals, as well as biological and radiological agents. Medical toxicologists care for people in clinical, academic, governmental and public health settings, and provide poison control center leadership. Important areas of medical toxicology include acute drug poisoning, adverse drug events, drug abuse, addiction and withdrawal, chemicals and hazardous materials, terrorism preparedness, venomous bites and stings, and environmental and workplace exposures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. ACGME Accredited Residency Program Requirements: Medical Toxicology (EM) 2 years with 3-4 years Emergency Medicine for a total of 5-6 years; for Medical Toxicology (Preventive Medicine) 2 years with 3 years Preventive Medicine for a total of 5 years. Medical Toxicology (Pediatrics): None. ABMS Approved Subspecialty Certificates (Emergency Medicine) (Pediatrics) (Preventive Medicine)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Neonatal-Perinatal Medicine

2080N0001X Neonatal-Perinatal Medicine Physician

A pediatrician who is the principal care provider for sick newborn infants. Clinical expertise is used for direct patient care and for consulting with obstetrical colleagues to plan for the care of mothers who have high-risk pregnancies.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Neurodevelopmental Disabilities

2080P0008X Pediatric Neurodevelopmental Disabilities Physician

A pediatrician who treats children having developmental delays or learning disorders including those associated with visual and hearing impairment, mental retardation, cerebral palsy, spina bifida, autism and other chronic neurologic conditions. This specialist provides medical consultation and education and assumes leadership in the interdisciplinary management of children with neurodevelopmental disorders. They may also focus on the early identification and diagnosis of neurodevelopmental disabilities in infants and young children as well as on changes that occur as the child with developmental disabilities grows.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Obesity Medicine

2080B0002X Pediatric Obesity Medicine Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [7/1/2015: new] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/201

Specialization: Pediatric Allergy/Immunology

2080P0201X Pediatric Allergy/Immunology Physician

A pediatrician who specializes in the diagnosis and treatment of allergies, allergic reactions, and immunologic diseases in children.

Source: National Uniform Claim Committee, 2009 [1/1/2010: title modified, definition added, source added] Additional Resources: A Certification of Special Qualifications (CSQ) is issued by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Pediatric Cardiology

2080P0202X Pediatric Cardiology Physician

A pediatric cardiologist provides comprehensive care to patients with cardiovascular problems. This specialist is skilled in selecting, performing and evaluating the structural and functional assessment of the heart and blood vessels, and the clinical evaluation of cardiovascular disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Critical Care Medicine

2080P0203X Pediatric Critical Care Medicine Physician

A pediatrician expert in advanced life support for children from the term or near-term neonate to the adolescent. This competence extends to the critical care management of life-threatening organ system failure from any cause in both medical and surgical patients and to the support of vital physiological functions. This specialist may have administrative responsibilities for intensive care units and also facilitates patient care among other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. ACGME Accredited Residency Program Requirements: 2 years of training with 3 years Pediatrics plus 1 year Pediatric Critical Care for certification for a total of 6 years. ABMS Approved Subspecialty Certificate (Pediatrics)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Emergency Medicine

2080P0204X Pediatric Emergency Medicine (Pediatrics) Physician

A pediatrician who has special qualifications to manage emergencies in infants and children.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Pediatric Endocrinology

2080P0205X Pediatric Endocrinology Physician

A pediatrician who provides expert care to infants, children and adolescents who have diseases that result from an abnormality in the endocrine glands (glands which secrete hormones). These diseases include diabetes mellitus, growth failure, unusual size for age, early or late pubertal development, birth defects, the genital region and disorders of the thyroid, the adrenal and pituitary glands.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Gastroenterology

2080P0206X Pediatric Gastroenterology Physician

A pediatrician who specializes in the diagnosis and treatment of diseases of the digestive systems of infants, children and adolescents. This specialist treats conditions such as abdominal pain, ulcers, diarrhea, cancer and jaundice and performs complex diagnostic and therapeutic procedures using lighted scopes to see internal organs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Hematology-Oncology

2080P0207X Pediatric Hematology & Oncology Physician

A pediatrician trained in the combination of pediatrics, hematology and oncology to recognize and manage pediatric blood disorders and cancerous diseases.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Pediatric Infectious Diseases

2080P0208X Pediatric Infectious Diseases Physician

A pediatrician trained to care for children in the diagnosis, treatment and prevention of infectious diseases. This specialist can apply specific knowledge to affect a better outcome for pediatric infections with complicated courses, underlying diseases that predispose to unusual or severe infections, unclear diagnoses, uncommon diseases and complex or investigational treatments.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Nephrology

2080P0210X Pediatric Nephrology Physician

A pediatrician who deals with the normal and abnormal development and maturation of the kidney and urinary tract, the mechanisms by which the kidney can be damaged, the evaluation and treatment of renal diseases, fluid and electrolyte abnormalities, hypertension and renal replacement therapy.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Pediatric Pulmonology

2080P0214X Pediatric Pulmonology Physician

A pediatrician dedicated to the prevention and treatment of all respiratory diseases affecting infants, children and young adults. This specialist is knowledgeable about the growth and development of the lung, assessment of respiratory function in infants and children, and experienced in a variety of invasive and noninvasive diagnostic techniques.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Rheumatology

2080P0216X Pediatric Rheumatology Physician

A pediatrician who treats diseases of joints, muscle, bones and tendons. A pediatric rheumatologist diagnoses and treats arthritis, back pain, muscle strains, common athletic injuries and "collagen" diseases.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Transplant Hepatology

2080T0004X Pediatric Transplant Hepatology Physician

A pediatrician with expertise in transplant hepatology encompasses the special knowledge and skill required of pediatric gastroenterologists to care for patients prior to and following hepatic transplantation; it spans all phases of liver transplantation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new] Additional Resources; American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 10/1/200

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Sleep Medicine

2080S0012X Pediatric Sleep Medicine Physician

A Pediatrician who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, www.aasm.org [7/1/2006: new]

Effective Date 10/1/200

Specialization: Sports Medicine

2080S0010X Pediatric Sports Medicine Physician

A pediatrician who is responsible for continuous care in the field of sports medicine, not only for the enhancement of health and fitness, but also for the prevention of injury and illness. A sports medicine physician must have knowledge and experience in the promotion of wellness and the prevention of injury. Knowledge about special areas of medicine such as exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation, epidemiology, physical evaluation, injuries (treatment and prevention and referral practice) and the role of exercise in promoting a healthy lifestyle are essential to the practice of sports medicine. The sports medicine physician requires special education to provide the knowledge to improve the healthcare of the individual engaged in physical exercise (sports) whether as an individual or in team participation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Phlebology

202K00000X Phlebology Physician

Phlebology is the medical discipline that involves the diagnosis and treatment of venous disorders, including spider veins, varicose veins, chronic venous insufficiency, venous leg ulcers, congenital venous abnormalities, venous thromboembolism and other disorders of venous origin. A phlebologist has attained a minimum of 50 hours of CME units in phlebology-related courses, and is knowledgeable of and trained in a variety of diagnostic techniques including physical examination, venous imaging techniques such as duplex ultrasound, CT and MR, plethysmographic techniques and laboratory evaluation related to venous thromboembolism. The phlebologist is also trained in a variety of therapeutic interventions, which may include compression, sclerotherapy, cutaneous vascular laser, endovenous thermoablation procedures (laser and radiofrequency) endovenous chemical ablation, surgical procedures (e.g., ambulatory phlebectomy, venous ligation), vasoactive medications and the management of venous thromboembolism.

Source: American College of Phlebology 12/2006. www.phelbology.org [1/1/2007: new, 7/1/2009: definition reformatted] Additional Resources: Training Programs, Fellowships, and/or Preceptorships: Certification exam is being established by the American Board of Phlebology. ACGME Accredited Residency Program Requirements: None

Effective Date 4/1/2007

Physical Medicine & Rehabilitation

208100000X Physical Medicine & Rehabilitation Physician

Physical medicine and rehabilitation, also referred to as rehabilitation medicine, is the medical specialty concerned with diagnosing, evaluating, and treating patients with physical disabilities. These disabilities may arise from conditions affecting the musculoskeletal system such as neck and back pain, sports injuries, or other painful conditions affecting the limbs, such as carpal tunnel syndrome. Alternatively, the disabilities may result from neurological trauma or disease such as spinal cord injury, head injury or stroke. A physician certified in physical medicine and rehabilitation is often called a physiatrist. The primary goal of the physiatrist is to achieve maximal restoration of physical, psychological, social and vocational function through comprehensive rehabilitation. Pain management is often an important part of the role of the physiatrist. For diagnosis and evaluation, a physiatrist may include the techniques of electromyography to supplement the standard history, physical, x-ray and laboratory examinations. The physiatrist has expertise in the appropriate use of therapeutic exercise, prosthetics (artificial limbs), orthotics and mechanical and electrical devices.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. American Osteopathic Board of Physical Medicine and Rehabilitation, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Physical Medicine and Rehabilitation.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Physical Medicine & Rehabilitation

Specialization: Brain Injury Medicine

2081P0301X Brain Injury Medicine (Physical Medicine & Rehabilitation) Physician

A Brain Injury Medicine physician specializes in disorders of brain function due to injury and disease. These disorders encompass a range of medical, physical, neurologic, cognitive, sensory, and behavioral disorders that result in psychosocial, educational, and vocational consequences.

Source: American Board of Physical Medicine and Rehabilitation, 2015. www.abpmr.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: Hospice and Palliative Medicine

2081H0002X Hospice and Palliative Medicine (Physical Medicine & Rehabilitation) Physician

A physical medicine and rehabilitation physician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Neuromuscular Medicine

2081N0008X Neuromuscular Medicine (Physical Medicine & Rehabilitation) Physician

A physician who specializes in neuromuscular medicine possesses specialized knowledge in the science, clinical evaluation and management of these disorders. This encompasses the knowledge of the pathology, diagnosis and treatment of these disorders at a level that is significantly beyond the training and knowledge expected of a general neurologist, child neurologist or physiatrist.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new] Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation.

Effective Date 10/1/200

Specialization: Pain Medicine

2081P2900X Pain Medicine (Physical Medicine & Rehabilitation) Physician

A physician who provides a high level of care, either as a primary physician or consultant, for patients experiencing problems with acute, chronic or cancer pain in both hospital and ambulatory settings. Patient care needs may also be coordinated with other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed] Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation. A subspecialty certificate was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Proposal under development.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Physical Medicine & Rehabilitation

Specialization: Pediatric Rehabilitation Medicine

2081P0010X Pediatric Rehabilitation Medicine Physician

A physiatrist who utilizes an interdisciplinary approach and addresses the prevention, diagnosis, treatment and management of congenital and childhood-onset physical impairments including related or secondary medical, physical, functional, psychosocial and vocational limitations or conditions, with an understanding of the life course of disability. This physician is trained in the identification of functional capabilities and selection of the best of rehabilitation intervention strategies, with an understanding of the continuum of care.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation. A subspecialty certificate for PRM was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Early discussions underway

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Spinal Cord Injury Medicine

2081P0004X Spinal Cord Injury Medicine Physician

A physician who addresses the prevention, diagnosis, treatment and management of traumatic spinal cord injury and non-traumatic etiologies of spinal cord dysfunction by working in an interdisciplinary manner. Care is provided to patients of all ages on a lifelong basis and covers related medical, physical, psychological and vocational disabilities and complications.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation. ACGME Accredited Residency Program Requirements: 1 year of training with 3-5 years in relevant specialty for a total of 4-6 years. ABMS Approved Subspecialty Certificate: (Physical Medicine and Rehabilitation)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Sports Medicine

2081S0010X Sports Medicine (Physical Medicine & Rehabilitation) Physician

A physician who specializes in Sports Medicine is responsible for continuous care related to the enhancement of health and fitness as well as the prevention of injury and illness. The specialist possesses knowledge and experience in the promotion of wellness and the prevention of injury from many areas of medicine such as exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation, epidemiology, physical evaluation and injuries. It is the goal of a Sports Medicine specialist to improve the healthcare of the individual engaged in physical exercise.

Source: American Board of Medical Specialties, 2009. www.abms.org [7/1/2009: definition added]

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Plastic Surgery

208200000X Plastic Surgery Physician

A plastic surgeon deals with the repair, reconstruction or replacement of physical defects of form or function involving the skin, musculoskeletal system, craniomaxillofacial structures, hand, extremities, breast and trunk and external genitalia or cosmetic enhancement of these areas of the body. Cosmetic surgery is an essential component of plastic surgery. The plastic surgeon uses cosmetic surgical principles to both improve overall appearance and to optimize the outcome of reconstructive procedures. The surgeon uses aesthetic surgical principles not only to improve undesirable qualities of normal structures but in all reconstructive procedures as well.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Plastic Surgery, 2007. http://www.abplsurg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Plastic Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Plastic Surgery Within the Head and Neck

2082S0099X Plastic Surgery Within the Head and Neck (Plastic Surgery) Physician

A plastic surgeon with additional training in plastic and reconstructive procedures within the head, face, neck and associated structures, including cutaneous head and neck oncology and reconstruction, management of maxillofacial trauma, soft tissue repair and neural surgery. The field is diverse and involves a wide age range of patients, from the newborn to the aged. While both cosmetic and reconstructive surgery is practiced, there are many additional procedures which interface with them.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Plastic Surgery, 2007. http://www.abplsurg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Plastic Surgery. A subspecialty certificate was approved by the ABMS in 2000. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Surgery of the Hand

2082S0105X Surgery of the Hand (Plastic Surgery) Physician

A plastic surgeon with additional training in the investigation, preservation, and restoration by medical, surgical and rehabilitative means of all structures of the upper extremity directly affecting the form and function of the hand and wrist.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Plastic Surgery, 2007. http://www.abplsurg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Plastic Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Preventive Medicine

Specialization: Addiction Medicine

2083A0300X Addiction Medicine (Preventive Medicine) Physician

A physician engaged in the subspecialty practice of Addiction Medicine who specializes in the prevention, evaluation, diagnosis, treatment, and recovery of persons with the disease of addiction.

Source: American Board of Preventive Medicine, www.theabpm.org [1/1/2019: new]

Effective Date 4/1/2019

Allopathic & Osteopathic Physicians

Preventive Medicine

Specialization: Aerospace Medicine

2083A0100X Aerospace Medicine Physician

Aerospace medicine focuses on the clinical care, research, and operational support of the health, safety, and performance of crewmembers and passengers of air and space vehicles, together with the support personnel who assist operation of such vehicles. This population often works and lives in remote, isolated, extreme, or enclosed environments under conditions of physical and psychological stress. Practitioners strive for an optimal human-machine match in occupational settings rich with environmental hazards and engineering countermeasures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. American Osteopathic Board of Preventive Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Clinical Informatics

2083C0008X Clinical Informatics Physician

Physicians who practice Clinical Informatics collaborate with other health care and information technology professionals to analyze, design, implement and evaluate information and communication systems that enhance individual and population health outcomes, improve patient care, and strengthen the clinician-patient relationship. Clinical Informaticians use their knowledge of patient care combined with their understanding of informatics concepts, methods, and tools to: assess information and knowledge needs of health care professionals and patients; characterize, evaluate, and refine clinical processes; develop, implement, and refine clinical decision support systems; and lead or participate in the procurement, customization, development, implementation, management, evaluation, and continuous improvement of clinical information systems.

Source: The American Board of Preventive Medicine, 2013 [1/1/2014: new] Additional Resources: The American Board of Preventive Medicine, www.theabpm.org

Effective Date 4/1/2014

Allopathic & Osteopathic Physicians

Preventive Medicine

Specialization: Medical Toxicology

2083T0002X Medical Toxicology (Preventive Medicine) Physician

Medical toxicologists are physicians who specialize in the prevention, evaluation, treatment and monitoring of injury and illness from exposures to drugs and chemicals, as well as biological and radiological agents. Medical toxicologists care for people in clinical, academic, governmental and public health settings, and provide poison control center leadership. Important areas of medical toxicology include acute drug poisoning, adverse drug events, drug abuse, addiction and withdrawal, chemicals and hazardous materials, terrorism preparedness, venomous bites and stings, and environmental and workplace exposures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Obesity Medicine

2083B0002X Obesity Medicine (Preventive Medicine) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [7/1/2015: new] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/201

Specialization: Occupational Medicine

2083X0100X Occupational Medicine Physician

Occupational medicine focuses on the health of workers, including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures. Practitioners in this field address the promotion of health in the work place, and the prevention and management of occupational and environmental injury, illness, and disability.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Preventive Medicine

Specialization: Preventive Medicine/Occupational Environmental Medicine

2083P0500X Preventive Medicine/Occupational Environmental Medicine Physician

A preventive medicine physician who specializes in preventive medicine/occupational-environmental medicine, which is focused on protecting the population from occupational and environmental conditions.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A General Certificate is issued by the American Osteopathic Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Public Health & General Preventive Medicine

2083P0901X Public Health & General Preventive Medicine Physician

Public health and general preventive medicine focuses on promoting health, preventing disease, and managing the health of communities and defined populations. These practitioners combine population-based public health skills with knowledge of primary, secondary, and tertiary prevention-oriented clinical practice in a wide variety of settings.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. American Osteopathic Board of Preventive Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Sports Medicine

2083S0010X Sports Medicine (Preventive Medicine) Physician

A preventive medicine physician who specializes in the diagnosis and treatment of sports related conditions and injuries.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) is issued by the American Osteopathic Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Allopathic & Osteopathic Physicians

Preventive Medicine

Specialization: Undersea and Hyperbaric Medicine

2083P0011X Undersea and Hyperbaric Medicine (Preventive Medicine) Physician

A specialist who treats decompression illness and diving accident cases and uses hyperbaric oxygen therapy to treat such conditions as carbon monoxide poisoning, gas gangrene, non-healing wounds, tissue damage from radiation and burns and bone infections. This specialist also serves as consultant to other physicians in all aspects of hyperbaric chamber operations and assesses risks and applies appropriate standards to prevent disease and disability in divers and other persons working in altered atmospheric conditions.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Psychiatry & Neurology

Specialization: Addiction Medicine

2084A0401X Addiction Medicine (Psychiatry & Neurology) Physician

A doctor of osteopathy board eligible/certified in the field of Psychiatry by the American Osteopathic Board of Neurology and Psychiatry is able to obtain a Certificate of Added Qualifications in the field of Addiction Medicine

Source: American Osteopathic Board of Neurology and Psychiatry, 2007 [1/1/2008: definition added, source added; 7/1/2011: modified source]

Additional Resources: http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Addiction Psychiatry

2084P0802X Addiction Psychiatry Physician

Addiction Psychiatry is a subspecialty of psychiatry that focuses on evaluation and treatment of individuals with alcohol, drug, or other substance-related disorders, and of individuals with dual diagnosis of substance-related and other psychiatric disorders.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Behavioral Neurology & Neuropsychiatry

2084B0040X Behavioral Neurology & Neuropsychiatry Physician

Behavioral Neurology & Neuropsychiatry is a medical subspecialty involving the diagnosis and treatment of neurologically based behavioral issues.

Source: National Uniform Claim Committee. [1/1/2012: new] Additional Resources: American Academy of Neurology, www.aan.com.

Effective Date 4/1/2012

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Brain Injury Medicine

2084P0301X Brain Injury Medicine (Psychiatry & Neurology) Physician

A Brain Injury Medicine physician specializes in disorders of brain function due to injury and disease. These disorders encompass a range of medical, physical, neurologic, cognitive, sensory, and behavioral disorders that result in psychosocial, educational, and vocational consequences.

Source: American Board of Physical Medicine and Rehabilitation, 2015. www.abpmr.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: Child & Adolescent Psychiatry

2084P0804X Child & Adolescent Psychiatry Physician

Child & Adolescent Psychiatry is a subspecialty of psychiatry with additional skills and training in the diagnosis and treatment of developmental, behavioral, emotional, and mental disorders of childhood and adolescence.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Clinical Neurophysiology

2084N0600X Clinical Neurophysiology Physician

Clinical Neurophysiology is a subspecialty with psychiatric or neurologic expertise in the diagnosis and management of central, peripheral, and autonomic nervous system disorders using combined clinical evaluation and electrophysiologic testing such as electroencephalography (EEG), electromyography (EMG), and nerve conduction studies (NCS).

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Diagnostic Neuroimaging

2084D0003X Diagnostic Neuroimaging (Psychiatry & Neurology) Physician

A licensed physician, who has completed a residency program in Neurology, and who has additional training, experience, and competence in the standards of performance and interpretation of Magnetic Resonance Imaging (MRI / MRA) of the head, spine, and peripheral nerves, and Computed Tomography (CT) of the head and spine. Physicians are trained in the administration of contrast media and the recognition and treatment of adverse reactions to contrast media. Neuroimaging training encompasses thorough knowledge of clinical neurology, neurophysiology, neuroanatomy, neurochemistry, neuropharmacology, and dynamics of cerebrospinal fluid circulation. Physicians possess special expertise in the technical aspects and clinical applications of each of the modalities and techniques of neuroimaging.

Source: American Academy of Neurology, www.aan.com [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Epilepsy

2084E0001X Epilepsy

Epilepsy is a subspecialty of neurology focused on the diagnosis and treatment of patients with epilepsy, including new-onset, medically refractory epilepsy, psychogenic nonepileptic seizures, and epilepsy in special populations (the elderly, women, patients with co-morbidities). Epilepsy is a multidisciplinary field that provides comprehensive care of the patient.

Source: American Epilepsy Society, www.aesnet.org

Effective Date 10/1/202

Specialization: Forensic Psychiatry

2084F0202X Forensic Psychiatry Physician

Forensic Psychiatry is a subspecialty with psychiatric focus on interrelationships with civil, criminal and administrative law, evaluation and specialized treatment of individuals involved with the legal system, incarcerated in jails, prisons, and forensic psychiatry hospitals.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Geriatric Psychiatry

2084P0805X Geriatric Psychiatry Physician

Geriatric Psychiatry is a subspecialty with psychiatric expertise in prevention, evaluation, diagnosis and treatment of mental and emotional disorders in the elderly, and improvement of psychiatric care for healthy and ill elderly patients.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Hospice and Palliative Medicine

2084H0002X Hospice and Palliative Medicine (Psychiatry & Neurology) Physician

A psychiatrist or neurologist with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Neurocritical Care

2084A2900X Neurocritical Care Physician

The medical subspecialty of Neurocritical Care is devoted to the comprehensive, multisystem care of the critically-ill neurological patient. Like other intensivists, the neurointensivist generally assumes the primary role for coordinating the care of his or her patients in the ICU, both the neurological and medical management of the patient. They may also provide consultative services for these patients as requested within the health system.

Source: Adapted from the United Council for Neurologic Subspecialties website definition at: http://www.ucns.org/go/subspecialty/neurocritical [7/1/2016: new]

Effective Date 10/1/201

Specialization: Neurodevelopmental Disabilities

2084P0005X Neurodevelopmental Disabilities Physician Physician

A pediatrician or neurologist who specializes in the diagnosis and management of chronic conditions that affect the developing and mature nervous system such as cerebral palsy, mental retardation and chronic behavioral syndromes, or neurologic conditions.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Psychiatry and Neurology, 2007. http://www.abpn.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Psychiatry and Neurology. A subspecialty certificate for NDN was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Ongoing early discussions regarding proposal.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Neurology

2084N0400X Neurology Physician

A Neurologist specializes in the diagnosis and treatment of diseases or impaired function of the brain, spinal cord, peripheral nerves, muscles, autonomic nervous system, and blood vessels that relate to these structures.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Neurology with Special Qualifications in Child Neurology

2084N0402X Neurology with Special Qualifications in Child Neurology Physician

A Child Neurologist specializes in neurology with special skills in diagnosis and treatment of neurologic disorders of the neonatal period, infancy, early childhood, and adolescence.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Neuromuscular Medicine

2084N0008X Neuromuscular Medicine (Psychiatry & Neurology) Physician

A neurologist or child neurologist who specializes in the diagnosis and management of disorders of nerve, muscle or neuromuscular junction, including amyotrophic lateral sclerosis, peripheral neuropathies (e.g., diabetic and immune mediated neuropathies), various muscular dystrophies, congenital and acquired myopathies, inflammatory myopathies (e.g., polymyositis, inclusion body myositis) and neuromuscular transmission disorders (e.g., myasthenia gravis, Lambert-Eaton myasthenic syndrome).

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new] Additional Resources: American Board of Psychiatry and Neurology, 2007. http://www.abpn.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Psychiatry and Neurology

Effective Date 10/1/200

Specialization: Obesity Medicine

2084B0002X Obesity Medicine (Psychiatry & Neurology) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [10/1/2007: new, 7/1/2015: title and definition modified] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/200

Specialization: Pain Medicine

2084P2900X Pain Medicine (Psychiatry & Neurology) Physician

A neurologist, child neurologists or psychiatrist who provides a high level of care, either as a primary physician or consultant, for patients experiencing problems with acute, chronic or cancer pain in both hospital and ambulatory settings. Patient care needs may also be coordinated with other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Psychiatry and Neurology, 2007. http://www.abpn.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Psychiatry and Neurology. A subspecialty certificate was approved by ABMS in 1998. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Psychiatry

2084P0800X Psychiatry Physician

A Psychiatrist specializes in the prevention, diagnosis, and treatment of mental disorders, emotional disorders, psychotic disorders, mood disorders, anxiety disorders, substance-related disorders, sexual and gender identity disorders and adjustment disorders. Biologic, psychological, and social components of illnesses are explored and understood in treatment of the whole person. Tools used may include diagnostic laboratory tests, prescribed medications, evaluation and treatment of psychological and interpersonal problems with individuals and families, and intervention for coping with stress, crises, and other problems.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Psychosomatic Medicine

2084P0015X Psychosomatic Medicine Physician

Psychosomatic Medicine is subspecialty in the diagnosis and treatment of psychiatric disorders and symptoms in complex medically ill patients. This subspecialty includes treatment of patients with acute or chronic medical, neurological, obstetrical or surgical illness in which psychiatric illness is affecting their medical care and/or quality of life such as HIV infection, organ transplantation, heart disease, renal failure, cancer, stroke, traumatic brain injury, high-risk pregnancy and COPD, among others. Patients also may be those who have a psychiatric disorder that is the direct consequence of a primary medical condition, or a somatoform disorder or psychological factors affecting a general medical condition. Psychiatrists specializing in Psychosomatic Medicine provide consultation-liaison services in general medical hospitals, attend on medical psychiatry inpatient units, and provide collaborative care in primary care and other outpatient settings.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Sleep Medicine

2084S0012X Sleep Medicine (Psychiatry & Neurology) Physician

A Psychiatrist or Neurologist who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, www.aasm.org [7/1/2006: new]

Effective Date 10/1/200

Specialization: Sports Medicine

2084S0010X Sports Medicine (Psychiatry & Neurology) Physician

A psychiatrist or neurologist who specializes in the diagnosis and treatment of sports related conditions and injuries.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Neurology and Psychiatry.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Vascular Neurology

2084V0102X Vascular Neurology Physician

Vascular Neurology is a subspecialty in the evaluation, prevention, treatment and recovery from vascular diseases of the nervous system. This subspecialty includes the diagnosis and treatment of vascular events of arterial or venous origin from a large number of causes that affect the brain or spinal cord such as ischemic stroke, intracranial hemorrhage, spinal cord ischemia and spinal cord hemorrhage.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Radiology

Specialization: Body Imaging

2085B0100X Body Imaging Physician

A Radiology doctor of Osteopathy that specializes in Body Imaging.

Source: National Uniform Claim Committee, 2008 [7/1/2008: definition added, source added]
Additional Resources: The American Osteopathic Board of Radiology no longer offers a certificate in this specialty.

Effective Date 4/1/2003

Specialization: Diagnostic Neuroimaging

2085D0003X Diagnostic Neuroimaging (Radiology) Physician

A licensed physician, who has completed a residency program in Neurology, and who has additional training, experience, and competence in the standards of performance and interpretation of Magnetic Resonance Imaging (MRI / MRA) of the head, spine, and peripheral nerves, and Computed Tomography (CT) of the head and spine. Physicians are trained in the administration of contrast media and the recognition and treatment of adverse reactions to contrast media. Neuroimaging training encompasses thorough knowledge of clinical neurology, neurophysiology, neuroanatomy, neurochemistry, neuropharmacology, and dynamics of cerebrospinal fluid circulation. Physicians possess special expertise in the technical aspects and clinical applications of each of the modalities and techniques of neuroimaging.

Source: American Academy of Neurology, www.aan.com [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Radiology

Specialization: Diagnostic Radiology

2085R0202X Diagnostic Radiology Physician

A radiologist who utilizes x-ray, radionuclides, ultrasound and electromagnetic radiation to diagnose and treat disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Diagnostic Ultrasound

2085U0001X Diagnostic Ultrasound Physician

A Radiology doctor of Osteopathy that specializes in Diagnostic Ultrasound.

Source: National Uniform Claim Committee, 2008 [7/1/2008: definition added, source added]
Additional Resources: The American Osteopathic Board of Radiology no longer offers a certificate in this specialty. [Note: In medical practice, Diagnostic Ultrasound is part of the scope of training and practice of a Diagnostic Radiologists - see Taxonomy Code 2085R0202X.]

Effective Date 4/1/2003

Specialization: Hospice and Palliative Medicine

2085H0002X Hospice and Palliative Medicine (Radiology) Physician

A radiologist with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Radiology

Specialization: Neuroradiology

2085N0700X Neuroradiology Physician

A radiologist who diagnoses and treats diseases utilizing imaging procedures as they relate to the brain, spine and spinal cord, head, neck and organs of special sense in adults and children.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Nuclear Radiology

2085N0904X Nuclear Radiology Physician

A radiologist who is involved in the analysis and imaging of radionuclides and radiolabeled substances in vitro and in vivo for diagnosis and the administration of radionuclides and radiolabeled substances for the treatment of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Radiology

2085P0229X Pediatric Radiology Physician

A radiologist who is proficient in all forms of diagnostic imaging as it pertains to the treatment of diseases in the newborn, infant, child and adolescent. This specialist has knowledge of both imaging and interventional procedures related to the care and management of diseases of children. A pediatric radiologist must be highly knowledgeable of all organ systems as they relate to growth and development, congenital malformations, diseases peculiar to infants and children and diseases that begin in childhood but cause substantial residual impairment in adulthood.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Radiology

Specialization: Radiation Oncology

2085R0001X Radiation Oncology Physician

A radiologist who deals with the therapeutic applications of radiant energy and its modifiers and the study and management of disease, especially malignant tumors.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Radiological Physics

2085R0205X Radiological Physics Physician

A radiological physicist deals with the diagnostic and therapeutic applications of roentgen rays, gamma rays from sealed sources, ultrasonic radiation and radio-frequency radiation, as well as the equipment associated with their production and use, including radiation safety.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Therapeutic Radiology

2085R0203X Therapeutic Radiology Physician

Definition to come...

Effective Date 4/1/2003

Specialization: Vascular & Interventional Radiology

2085R0204X Vascular & Interventional Radiology Physician

A radiologist who diagnoses and treats diseases by various radiologic imaging modalities. These include fluoroscopy, digital radiography, computed tomography, sonography and magnetic resonance imaging.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Surgery

208600000X Surgery Physician

A general surgeon has expertise related to the diagnosis - preoperative, operative and postoperative management - and management of complications of surgical conditions in the following areas: alimentary tract; abdomen; breast, skin and soft tissue; endocrine system; head and neck surgery; pediatric surgery; surgical critical care; surgical oncology; trauma and burns; and vascular surgery. General surgeons increasingly provide care through the use of minimally invasive and endoscopic techniques. Many general surgeons also possess expertise in transplantation surgery, plastic surgery and cardiothoracic surgery.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. American Osteopathic Board of Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Hospice and Palliative Medicine

2086H0002X Hospice and Palliative Medicine (Surgery) Physician

A surgeon with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Pediatric Surgery

2086S0120X Pediatric Surgery Physician

A surgeon with expertise in the management of surgical conditions in premature and newborn infants, children and adolescents.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Plastic and Reconstructive Surgery

2086S0122X Plastic and Reconstructive Surgery Physician

A surgeon who specializes in plastic and reconstructive surgery.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A General Certificate is issued by the American Osteopathic Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Allopathic & Osteopathic Physicians

Surgery

Specialization: Surgery of the Hand

2086S0105X Surgery of the Hand (Surgery) Physician

A surgeon with expertise in the investigation, preservation and restoration by medical, surgical and rehabilitative means, of all structures of the upper extremity directly affecting the form and function of the hand and wrist.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Surgical Critical Care

2086S0102X Surgical Critical Care Physician

A surgeon with expertise in the management of the critically ill and postoperative patient, particularly the trauma victim, who specializes in critical care medicine diagnoses, treats and supports patients with multiple organ dysfunction. This specialist may have administrative responsibilities for intensive care units and may also facilitate and coordinate patient care among the primary physician, the critical care staff and other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. American Osteopathic Board of Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Surgical Oncology

2086X0206X Surgical Oncology Physician

A surgical oncologist is a well-qualified surgeon who has obtained additional training and experience in the multidisciplinary approach to the prevention, diagnosis, treatment, and rehabilitation of cancer patients, and devotes a major portion of his or her professional practice to these activities and cancer research.

Source: Society of Surgical Oncology, 2007 [1/1/2008: definition added, source added, 7/1/2009: definition reformatted] Additional Resources: http://www.surgonc.org/ ; American Board of Medical Specialties, 2007, www.abms.org ; American Board of Surgery, 2007, http://www.absurgery.org/ Surgical oncology is a recognized fellowship subspecialty program of surgery. Separate board certification is not currently offered.

Effective Date 4/1/2003 Last Modified Date 1/1/2008

Allopathic & Osteopathic Physicians

Surgery

Specialization: Trauma Surgery

2086S0127X Trauma Surgery Physician

Trauma surgery is a recognized subspecialty of general surgery. Trauma surgeons are physicians who have completed a five-year general surgery residency and usually continue with a one to two year fellowship in trauma and/or surgical critical care, typically leading to additional board certification in surgical critical care. There is no trauma surgery board certification at this point. To obtain board certification in surgical critical care, a fellowship in surgical critical care or anesthesiology critical care must be completed during or after general surgery residency.

Source: American Board of Surgery, 2007 [1/1/2008: definition added, source added] Additional Resources: http://www.absurgery.org/.

Effective Date 4/1/2003 Last Modified Date 1/1/2008

Specialization: Vascular Surgery

2086S0129X Vascular Surgery Physician

A surgeon with expertise in the management of surgical disorders of the blood vessels, excluding the intracranial vessels or the heart.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. American Osteopathic Board of Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Thoracic Surgery (Cardiothoracic Vascular Surgery)

208G00000X Thoracic Surgery (Cardiothoracic Vascular Surgery) Physician

A thoracic surgeon provides the operative, perioperative and critical care of patients with pathologic conditions within the chest. Included is the surgical care of coronary artery disease, cancers of the lung, esophagus and chest wall, abnormalities of the trachea, abnormalities of the great vessels and heart valves, congenital anomalies, tumors of the mediastinum and diseases of the diaphragm. The management of the airway and injuries of the chest is within the scope of the specialty.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Thoracic Surgery, 2007. http://www.abts.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Thoracic Surgery. Thoracic surgeons have the knowledge, experience and technical skills to accurately diagnose, operate upon safely, and effectively manage patients with thoracic diseases of the chest. This requires substantial knowledge of cardiorespiratory physiology and oncology, as well as capability in the use of heart assist devices, management of abnormal heart rhythms and drainage of the chest cavity, respiratory support systems, endoscopy and invasive and noninvasive diagnostic techniques.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Transplant Surgery

204F00000X Transplant Surgery Physician

Definition to come.

Effective Date 4/1/2003

Urology

208800000X Urology Physician

A urologist manages benign and malignant medical and surgical disorders of the genitourinary system and the adrenal gland. This specialist has comprehensive knowledge of and skills in endoscopic, percutaneous and open surgery of congenital and acquired conditions of the urinary and reproductive systems and their contiguous structures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Urology, 2007. http://www.abu.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Urology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Female Pelvic Medicine and Reconstructive Surgery

2088F0040X Female Pelvic Medicine and Reconstructive Surgery (Urology) Physician

A subspecialist in Female Pelvic Medicine and Reconstructive Surgery is a physician in Urology or Obstetrics and Gynecology who, by virtue of education and training, is prepared to provide consultation and comprehensive management of women with complex benign pelvic conditions, lower urinary tract disorders, and pelvic floor dysfunction. Comprehensive management includes those diagnostic and therapeutic procedures necessary for the total care of the patient with these conditions and complications resulting from them.

Source: American Board of Medical Specialties, 2011. [1/1/2012: new] Resources: www.abms.org

Effective Date 4/1/2012

Specialization: Pediatric Urology

2088P0231X Pediatric Urology Physician

Surgeons who can diagnose, treat, and manage children's urinary and genital problems. A pediatric urologist devotes a minimum of 50% of his or her practice to the urologic problems of infants, children, and adolescents. Pediatric urologists generally provide the following services: the evaluation and management of voiding disorders; vesicoureteral reflux, and urinary tract infections that require surgery; surgical reconstruction of the urinary tract (kidneys, ureters, and bladder) including genital abnormalities, hypospadias, and intersex conditions; surgery for groin conditions in childhood and adolescence (undescended testes, hydrocele/hernia, varicocele).

Source: American Academy of Pediatrics [7/1/2006: new]

Effective Date 10/1/200

Behavioral Health & Social Service Providers

Assistant Behavior Analyst

106E00000X Assistant Behavior Analyst

An assistant behavior analyst is qualified by Behavior Analyst Certification Board certification and/or a state-issued license or credential in behavior analysis to practice under the supervision of an appropriately credentialed professional behavior analyst. An assistant behavior analyst delivers services consistent with the dimensions of applied behavior analysis and supervision requirements defined in state laws or regulations and/or national certification standards. Common services may include, but are not limited to, conducting behavioral assessments, analyzing data, writing behavior-analytic treatment plans, training and supervising others in implementation of components of treatment plans, and direct implementation of treatment plans.

Association of Professional Behavior Analysts, www.apbahome.net and Behavior Analyst Certification Board (http://www.bacb.com) [7/1/2016: new]

Effective Date 10/1/201

Behavior Analyst

103K00000X Behavioral Analyst

A behavior analyst is qualified by at least a master's degree and Behavior Analyst Certification Board certification and/or a state-issued credential (such as a license) to practice behavior analysis independently. Behavior analysts provide the required supervision to assistant behavior analysts and behavior technicians. A behavior analyst delivers services consistent with the dimensions of applied behavior analysis. Common services may include, but are not limited to, conducting behavioral assessments, analyzing data, writing and revising behavior-analytic treatment plans, training others to implement components of treatment plans, and overseeing implementation of treatment plans.

Source: Association of Professional Behavior Analysts, www.apbahome.net and Behavior Analyst Certification Board (http://www.bacb.com) [7/1/2008: new, 1/1/2016: modified definition]

Effective Date 10/1/200 Last Modified Date 1/1/2016

Behavior Technician

106S00000X Behavior Technician

The behavior technician is a paraprofessional who practices under the close, ongoing supervision of a behavior analyst or assistant behavior analyst certified by the Behavior Analyst Certification Board and/or credentialed by a state (such as through licensure). The behavior technician is primarily responsible for the implementation of components of behavior-analytic treatment plans developed by the supervisor. That may include collecting data on treatment targets and conducting certain types of behavioral assessments (e.g., stimulus preference assessments). The behavior technician does not design treatment or assessment plans or procedures but provides services as assigned by the supervisor responsible for his or her work.

Association of Professional Behavior Analysts, www.apbahome.net and Behavior Analyst Certification Board (http://www.bacb.com) [7/1/2016: new]

Effective Date 10/1/201

Behavioral Health & Social Service Providers

Clinical Neuropsychologist

103G00000X Clinical Neuropsychologist

A clinical psychologist who applies principles of assessment and intervention based upon the scientific study of human behavior as it relates to normal and abnormal functioning of the central nervous system. The specialty is dedicated to enhancing the understanding of brain-behavior relationships and the application of such knowledge to human problems.

Source: American Psychological Association, www.apa.org [1/1/2007: title modified, 1/1/2019: definition modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Specialization: Clinical

103GC0700X Deactivated - Clinical Neuropsychologist

[1/1/2007: marked inactive, use 103G00000X]

Effective Date 4/1/2002 Last Modified Date 1/1/2007 Deactivation Date 3/31/2007

Counselor

101Y00000X Counselor

A provider who is trained and educated in the performance of behavior health services through interpersonal communications and analysis. Training and education at the specialty level usually requires a master's degree and clinical experience and supervision for licensure or certification.

Sources: Abridged from definitions provided by the National Board of Certified Counselors and the American Association of Pastoral Counselors.

Effective Date 4/1/2002

Specialization: Addiction (Substance Use Disorder)

101YA0400X Addiction (Substance Use Disorder) Counselor

Definition to come...

Effective Date 4/1/2002

Specialization: Mental Health

101YM0800X Mental Health Counselor

Definition to come...

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Counselor

Specialization: Pastoral

101YP1600X Pastoral Counselor

Definition to come...

Effective Date 4/1/2002

Specialization: Professional

101YP2500X Professional Counselor

Definition to come...

Effective Date 4/1/2002

Specialization: School

101YS0200X School Counselor

Definition to come...

Effective Date 4/1/2002

Drama Therapist

101200000X Drama Therapist

Drama therapists are trained in the intentional use of drama and theatre processes to achieve therapeutic goals. Drama therapists provide psychotherapy for individuals living with mental health and behavioral concerns that may result in psychological suffering, impaired relationships, or distress in daily activities. Drama therapy promotes wellness and healing within the context of a therapeutic relationship for individuals of varying ability levels across the lifespan. Drama therapy can take many forms depending on individual and group needs, skill and ability levels, interests, and therapeutic goals. Processes and techniques may include improvisation, theater games, storytelling, and enactment.

Source: North American Drama Therapy Association, www.nadta.org [1/1/2021: new]

Effective Date 4/1/2021

Marriage & Family Therapist

106H00000X Marriage & Family Therapist

A marriage and family therapist is a person with a master's degree in marriage and family therapy, or a master's or doctoral degree in a related mental health field with substantially equivalent coursework in marriage and family therapy, who receives supervised clinical experience, or a person who meets the state requirements to practice as a marriage and family therapist. A marriage and family therapist treats mental and emotional disorders within the context of marriage and family systems. A marriage and family therapist provides mental health and counseling services to individuals, couples, families, and groups.

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Poetry Therapist

102X00000X Poetry Therapist

A medical or mental health professional who has attained credentials after satisfactorily completing a poetry therapy training program approved by the National Federation for Biblio/Poetry Therapy (NFBPT). Training includes didactic work, peer group experience, and supervised practicum.

An NFBPT credentialed certified poetry therapist (CPT) or registered poetry therapist (PTR) integrates discussion of published literature and reflective or creative writing into the psychotherapeutic process to achieve goals of emotional well-being, symptom reduction, and improved interpersonal communication.

Certified poetry therapists and registered poetry therapists are licensed mental health professionals with advanced training in the theory and practice of poetry therapy. CPTs and PTRs are qualified to work independently with emotionally troubled populations in clinical, rehabilitative, community and educational institutions. They also work with emotionally healthy individuals adjusting to developmental issues, life crises, or disabilities. The PTR completes an advanced level of training and fieldwork, commensurate with the highest levels of clinical practice. The terms poetry therapy, applied poetry facilitation, journal therapy, bibliotherapy, biblio/poetry therapy, and poetry/journal therapy reflect the interactive use of literature and/or writing to promote personal growth and emotional healing. In addition to poetry, poetry therapy applies all forms or written and spoken language including story, myth, folk and fairy tale and other genres of poetic expression as well as journal, memoir, and narrative. The poetry therapy process integrates discussion of published literature and reflective or creative writing for expression and communication of thoughts and feelings to facilitate participants' emotional well-being. The field of poetry therapy encompasses all of these modalities, though only a duly trained and licensed clinical practitioner can be credentialed as CPT or PTR.

Source: The National Federation for Biblio/Poetry Therapy [7/1/2007: new]

Effective Date 10/1/200

Psychoanalyst

102L00000X Psychoanalyst

Psychoanalysis is a comprehensive, theoretical framework which, when applied to a treatment process, consists of an intensive verbal, therapeutic relationship between an analyst and an analysand which aims for symptom relief, emotional growth, and personal integration. The psychoanalytic treatment process includes, but is not limited to, the recognition of unconscious processes and conflicts; the significance of developmental influences; and the impact of resistances, defenses, transference and countertransference phenomena. Treatment is enhanced by an understanding developed in the analyst's training and personal analysis of unconscious manifestations, such as dreams, slips of the tongue, fantasies and day dreams. Psychoanalytic technique varies in relation to theoretical orientation.

Source: Registry of Psychoanalysts published by the National Association for the Advancement of Psychoanalysis [1/1/2007: new; 7/1/2007: definition changed, source changed]

Effective Date 4/1/2007 Last Modified Date 7/1/2007

Behavioral Health & Social Service Providers

Psychologist

103T00000X Psychologist

A psychologist is an individual who is licensed to practice psychology which is defined as the observation, description, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures, for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, and mental health. The practice of psychology includes, but is not limited to, psychological testing and the evaluation or assessment of personal characteristics, such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; diagnosis and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological aspects of physical illness, accident, injury, or disability; and psycheducational evaluation, therapy, remediation, and consultation. Psychological services may be rendered to individuals, families, groups and the public.

Source: American Psychological Association [1/1/2007: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Specialization: Addiction (Substance Use Disorder)

103TA0400X Addiction (Substance Use Disorder) Psychologist

A psychologist with a proficiency that involves the application of psychological treatment of addiction stemming from the use of alcohol and other psychoactive substances (e.g., nicotine, marijuana, cocaine, heroin) or behavioral addictions (e.g., gambling) with the aim of cessation or reduction of use and/or the amelioration of emotional, behavioral, interpersonal and other problems arising from the addictive behavior.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Additional Resources: The APA proficiency is Addiction Psychology.

Effective Date 4/1/2002

Specialization: Adult Development & Aging

103TA0700X Adult Development & Aging Psychologist

A psychologist who specializes in geropsychology, which applies the knowledge and methods of psychology to understanding and helping older persons and their families to maintain well-being, overcome problems and achieve maximum potential during later life. Professional geropsychology appreciates the wide diversity among older adults, the complex ethical issues that can arise in geriatric practice and the importance of interdisciplinary models of care.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Additional Resources: The APA specialty is "Geropsychology."

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Psychologist

Specialization: Clinical

103TC0700X Clinical Psychologist

A psychologist who provides continuing and comprehensive mental and behavioral health care for individuals and families; consultation to agencies and communities; training, education and supervision; and research-based practice. It is a specialty in breadth -- one that is broadly inclusive of severe psychopathology -- and marked by comprehensiveness and integration of knowledge and skill from a broad array of disciplines within and outside of psychology proper. The scope of clinical psychology encompasses all ages, multiple diversities and varied systems.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Effective Date 4/1/2002

Specialization: Clinical Child & Adolescent

103TC2200X Clinical Child & Adolescent Psychologist

A psychologist who develops and applies scientific knowledge to the delivery of psychological services to infants, toddlers, children and adolescents within their social context. Of particular importance to the specialty of clinical child psychology is an understanding of the basic psychological needs of children and adolescents, and how the family and other social contexts influence the socio-emotional adjustment, cognitive development, behavioral adaptation and health status of children and adolescents.

Source: American Psychological Association, www.apa.org [1/1/2007: title modified, 1/1/2019: new definition]

Additional Resources: The APA specialty is "Clinical Child Psychology."

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Specialization: Cognitive & Behavioral

103TB0200X Cognitive & Behavioral Psychologist

A psychologist who reflects an experimental-clinical approach distinguished by use of principles of human learning and development and theories of cognitive processing to promote meaningful change in maladaptive human behavior and thinking.

Source: American Psychological Association, www.apa.org [1/1/2007: title modified, 1/1/2019: new definition]

Additional Resources: The APA specialty is "Behavioral and Cognitive Psychology."

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Behavioral Health & Social Service Providers

Psychologist

Specialization: Counseling

103TC1900X Counseling Psychologist

A psychologist who specializes in general practice and health service. It focuses on how people function both personally and in their relationships at all ages. Counseling psychology addresses the emotional, social, work, school and physical health concerns people may have at different stages in their lives, focusing on typical life stresses and more severe issues with which people may struggle as individuals and as a part of families, groups and organizations. Counseling psychologists help people with physical, emotional and mental health issues improve their sense of well-being, alleviate feelings of distress and resolve crises. They also provide assessment, diagnosis, and treatment of more severe psychological symptoms.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Effective Date 4/1/2002

Specialization: Educational

103TE1000X Deactivated - Psychologist

[1/1/2007: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2007

Specialization: Exercise & Sports

103TE1100X Exercise & Sports Psychologist

A psychologist with a proficiency in sports psychology that uses psychological knowledge and skills to address optimal performance and well-being of athletes, developmental and social aspects of sports participation, and systemic issues associated with sports settings and organizations. APA recognizes sport psychology as a proficiency acquired after a doctoral degree in one of the primary areas of psychology and licensure as a psychologist. This proficiency does not include those who have earned a doctoral degree in sport psychology but are not licensed psychologists. Sport Psychology interventions are designed to assist athletes and other sports participants (e.g., coaches, administrators, parents) from a wide array of settings, levels of competition, and ages, ranging from recreational youth participants to professional and Olympic athletes to master's level performers.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Additional Resources: The APA proficiency is "Sport Psychology."

Effective Date 4/1/2002

Specialization: Family

103TF0000X Family Psychologist

A psychologist whose specialty is founded on principles of systems theory with the interpersonal system of the family the focus of assessment, intervention and research.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Additional Resources: The APA specialty is "Couple and Family Psychology."

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Psychologist

Specialization: Forensic

103TF0200X Forensic Psychologist

A psychologist whose specialty is characterized by activities primarily intended to provide professional psychological expertise within the judicial and legal systems.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Effective Date 4/1/2002

Specialization: Group Psychotherapy

103TP2701X Group Psychotherapy Psychologist

A psychologist who specializes in group psychology and group psychotherapy that is an evidenced-based specialty that prepares group leaders to identify and capitalize on developmental and healing possibilities embedded in the interpersonal/intrapersonal functioning of individual group members as well as collectively for the group. Emphasis is placed on the use of group dynamics to assist and treat individual group members. The specialty is applicable to all age groups, children, adolescents, adults and older adults, for a wide variety of conditions and concerns, and in numerous and diverse settings.

Source: American Psychological Association, www.apa.org [1/1/2007: modified title, 1/1/2019: new definition]

Additional Resources: The APA specialty is "Group Psychology and Group Psychotherapy."

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Specialization: Health

103TH0004X Health Psychologist

A psychologist who specializes in clinical health psychology that investigates and implements clinical services across diverse populations and settings to promote health and well-being and to prevent, treat, and manage illness and disability. Clinical health psychology sees health as the confluence of psychological, social, cultural, and biological factors and applies this understanding to professional activities including:
* Research
* Clinical service
* Consulting with, educating, and supervising other health care providers and psychologists
* Advising organizations, institutions, the public, and policymakers

Source: American Psychological Association, www.apa.org [1/1/2007: new, 7/1/2008: definition added, source added, 1/1/2019: definition modified, source modified] Additional Resources: The APA specialty is "Clinical Health Psychology."

Effective Date 4/1/2007

Specialization: Health Service

103TH0100X Health Service Psychologist

A psychologist, certified/licensed at the independent practice level in his/her state, who is duly trained and experienced in the delivery of direct, preventative, assessment, and therapeutic intervention services to individuals whose growth, adjustment, or functioning is actually impaired or is demonstrably at high risk of impairment (1974).

Source: National Register of Health Service Providers in Psychology website http://www.nationalregister.org/about_NR.html [7/1/2006: modified title, added definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Behavioral Health & Social Service Providers

Psychologist

Specialization: Intellectual & Developmental Disabilities

103TM1800X Intellectual & Developmental Disabilities Psychologist

Definition to come...

[1/1/2021: modified title]

Effective Date 4/1/2002 Last Modified Date 1/1/2021

Specialization: Men & Masculinity

103TM1700X Deactivated - Psychologist Men & Masculinity

[1/1/2007: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2007

Specialization: Prescribing (Medical)

103TP0016X Prescribing (Medical) Psychologist

A licensed, doctoral-level psychologist authorized to prescribe and has undergone specialized education and training in preparation for prescriptive practice and has passed an examination accepted by the state board of psychology relevant to establishing competence for prescribing, and has received from the state board of psychology a current certificate granting prescriptive authority, which has not been revoked or suspended.

Source: American Psychological Association, www.apa.org [1/1/2007: new, 1/1/2019: definition modified, source modified]

Effective Date 4/1/2007

Specialization: Psychoanalysis

103TP0814X Psychoanalysis Psychologist

A psychologist whose specialty is distinguished from other specialties by its body of knowledge and its intensive treatment approaches. It aims at structural changes and modifications of a person's personality. Psychoanalysis promotes awareness of unconscious, maladaptive and habitually recurrent patterns of emotion and behavior, allowing previously unconscious aspects of the self to become integrated and promoting optimal functioning, healing and creative expression.

Source: American Psychological Association, www.apa.org [1/1/2019, definition modified, source modified]

Effective Date 4/1/2002

Specialization: Psychotherapy

103TP2700X Deactivated - Psychologist Psychotherapy

[1/1/2007: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2007

Behavioral Health & Social Service Providers

Psychologist

Specialization: Rehabilitation

103TR0400X Rehabilitation Psychologist

A psychologist who specializes in the study and application of psychological principles on behalf of persons who have disability due to injury or illness. Rehabilitation psychologists, often within teams, assess and treat cognitive, emotional, and functional difficulties, and help people to overcome barriers to participation in life activities. Rehabilitation psychologists are involved in practice, research, and advocacy, with the broad goal of fostering independence and opportunity for people with disabilities.

Source: American Psychological Association, www.apa.org [1/1/2019: definition added]

Effective Date 4/1/2002

Specialization: School

103TS0200X School Psychologist

A psychologist whose specialty is concerned with the science and practice of psychology with children, youth, families; learners of all ages; and the schooling process. The basic education and training of school psychologists prepares them to provide a range of psychological diagnosis, assessment, intervention, prevention, health promotion, and program development and evaluation services with a special focus on the developmental processes of children and youth within the context of schools, families and other systems. School psychologists are prepared to intervene at the individual and system level, and develop, implement, and evaluate preventive programs. In these efforts, they conduct ecologically valid assessments and intervene to promote positive learning environments within which children and youth from diverse backgrounds to ensure that all have equal access to effective educational and psychological services that promote healthy development

Source: American Psychological Association, www.apa.org [1/1/2019: definition added]

Effective Date 4/1/2002

Specialization: Women

103TW0100X Deactivated - Psychotherapy Women

[1/1/2007: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2007

Social Worker

104100000X Social Worker

A social worker is a person who is qualified by a Social Work degree, and licensed, certified or registered by the state as a social worker to practice within the scope of that license. A social worker provides assistance and counseling to clients and their families who are dealing with social, emotional and environmental problems. Social work services may be rendered to individuals, families, groups, and the public.

Source: National Association of Social Workers, 2009 [7/1/2009: definition modified]

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Social Worker

Specialization: Clinical

1041C0700X Clinical Social Worker

A social worker who holds a master's or doctoral degree in social work from an accredited school of social work in addition to at least two years of post-master's supervised experience in a clinical setting. The social worker must be licensed, certified, or registered at the clinical level in the jurisdiction of practice. A clinical social worker provides direct services, including interventions focused on interpersonal interactions, intrapsychic dynamics, and life management issues. Clinical social work services are based on bio-psychosocial perspectives. Services consist of assessment, diagnosis, treatment (including psychotherapy and counseling), client-centered advocacy, consultation, evaluation, and prevention of mental illness, emotional, or behavioral disturbances.

Source: National Association of Social Workers, 2008 [7/1/2009: definition modified]

Effective Date 4/1/2002

Specialization: School

1041S0200X School Social Worker

Definition to come...

Effective Date 4/1/2002

Chiropractic Providers

Chiropractor

111N00000X Chiropractor

A provider qualified by a Doctor of Chiropractic (D.C.), licensed by the State and who practices chiropractic medicine -that discipline within the healing arts which deals with the nervous system and its relationship to the spinal column and its interrelationship with other body systems.

Effective Date 4/1/2002

Specialization: Independent Medical Examiner

111NI0013X Independent Medical Examiner Chiropractor

A special evaluator not involved with the medical care of the individual examinee that impartially evaluates the care being provided by other practitioners to clarify clinical, disability, liability or other case

Source: American Board of Independent Medical Examiners [1/1/2007: new]

Effective Date 4/1/2007

Chiropractic Providers

Chiropractor

Specialization: Internist

111NI0900X Internist Chiropractor

The chiropractic internist may serve as a primary care physician or may see patients referred from other providers for evaluation and co-management. Evaluation is focused on the early detection of functional, nutritional, and pathological disorders. A chiropractic internist utilizes the diagnostic instruments necessary for proper examination. In cases where laboratory examination is necessary, a chiropractic internist utilizes a recognized reference laboratory facility. A chiropractic internist may manage his or her own cases or may refer to another specialist when prudent to do so. The chiropractic internist utilizes documented natural therapies, therapeutic lifestyle changes, patient education and other resources to promote patient health and avoidance of disease.

Source: American Chiropractic Association, 2008 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Neurology

111NN0400X Neurology Chiropractor

Chiropractic Neurology is defined as the field of functional neurology that engages the internal - and external environment of the individual in a structured and targeted approach to affect positive changes in the nervous system and consequently the physiology and behavior of an individual. Chiropractic Neurologists are board-certified specialists in non-drug, non-surgical care for those with neurologically based health problems. There are many conditions people suffer from that are in this broad category: learning and attention disorders, headaches, vertigo, pain syndromes, developmental disorders, nerve injury, spinal cord injury, head injury or stroke, movement disorders, and many other conditions.

Source: American Chiropractic Neurology Board, 2008 & American Chiropractic Association, 2008 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Nutrition

111NN1001X Nutrition Chiropractor

Chiropractic Nutrition is that specialty within the chiropractic profession that deals with the overall factors that affect the patient's ability to maintain the manipulative correction and thus sustain better neurological integrity. The Chiropractic Nutrition Specialist will perform extensive research on the patient's previous health history, ethnicity, and any family history related to what the patient is being treated for. Patients fill out questionnaires concerning dietary and sleep patterns and previous or present symptomology. A nutrition examination would be performed to assess areas such as absorption rates, adrenal function, kidney health, lung health etc. The patient is often instructed on how to check the pH of their saliva and urine, test for the presence of Candida Albicans, etc., at home. Outside laboratory testing includes blood, urine, hair analysis, food allergy testing etc. The patient's prescription and over the counter medications are recorded and analyzed.

Source: American Chiropractic Association, 2008 [7/1/2009: definition added]

Effective Date 4/1/2002

Chiropractic Providers

Chiropractor

Specialization: Occupational Health

111NX0100X Occupational Health Chiropractor

Occupational Health is that specialty within the chiropractic profession that deals with the prevention and management of work related injuries. It also considers and assists clients with State and Federal Compliance assistance. Occupational Health goes much farther than simply treating injured workers however. This may mean working with clients to promote optimum safety and ergonomic principles, interacting with the injured worker to promote safety and prevent future injuries, assisting a company with accident investigation to identify root cause, redesigning a workstation to eliminate hazards, working with safety teams, providing training programs etc. The list of potential services that the specialist can interact with a client company or patient is lengthy and varied involving both in office services as well as on site services.

Source: American Chiropractic Association, 2008 [7/1/2009: title modified, definition added]

Effective Date 4/1/2002

Specialization: Orthopedic

111NX0800X Orthopedic Chiropractor

Chiropractic Orthopedics is defined as that branch of chiropractic medicine that includes the continued acquisition of knowledge relative to both normal functions and diseases of the human body as they relate to the bones, joints, capsules, discs, muscles, ligaments, tendons, their complete neurological and vascular components, referred organ systems and contiguous tissues. This also includes the development and perfection of skills relative to health maintenance when such exists and when not, the investigations, historical review, physical detection, correlative diagnosis development and complete management of any disorder within the bounds defined herein. Also necessary is the delivery of the combined knowledge and skill on a primary basis to patients who both need and desire this service to the eventual outcome of remissions, whenever resolution is not readily achievable. In addition the certified chiropractic orthopedist provides consultation services at the request of other qualified doctors seeking assistance in the care of their patients. The chiropractic orthopedist may also engage in the teaching and or research of subjects and materials relevant to pursuing the quest for knowledge in the ever changing field of the orthopedic specialty.

Source: American Chiropractic Association, 2008 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Pediatric Chiropractor

111NP0017X Pediatric Chiropractor

The Pediatric Chiropractor is a chiropractor with specialized, advanced training and certification in the evaluation, care and management of health and wellness conditions of infancy, childhood and adolescence. This specialist provides primary, comprehensive, therapeutic and preventative chiropractic health care for newborns through adolescents.

Source: Council on Chiropractic Pediatrics, American Chiropractic Association, 2007 [1/1/2008: new]

Effective Date 4/1/2002

Chiropractic Providers

Chiropractor

Specialization: Radiology

111NR0200X Radiology Chiropractor

Chiropractic radiology is a referral specialty that provides consultation services at the request of other qualified doctors. Chiropractic radiologists provide consultation in health care facilities (private offices, hospitals and teaching institutions) to meet the needs of referring doctors and their patients. The quality of the consultative services by the chiropractic radiologist in independent practice is reflected by the quality of their professional credentials. Chiropractic radiologists recommend, supervise, and interpret radiologic studies as well as advanced imaging procedures. They advise referring physicians on the necessity and appropriateness of radiologic services and whether to select or to avoid certain diagnostic or clinical procedures. In some instances the radiologist may act as a private practitioner. They may conduct research and apply diagnostic radiologic procedures and may be called upon to act as expert witnesses in matters of litigation.

Chiropractic radiologists are also concerned with imaging technology including image production, demonstration of normal and abnormal anatomy, and the interaction of energy and matter. The advances in the technological facets of radiology are so rapid that only qualified radiologists can reasonably be expected to maintain the high level of proficiency required to supervise and interpret these procedures. The practice of radiology continuously involves the application of this technology to patient imaging and treatment. It is now well recognized that chiropractic radiology includes, but is not limited to, plain film radiography, fluoroscopy, tomography, ultrasonography, radioisotope imaging, computed tomography, digital radiography, and magnetic resonance imaging. Individual practices may vary by intent, licensure, and scope of practice laws.

Source: American Chiropractic Board of Radiology, 2009 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Rehabilitation

111NR0400X Rehabilitation Chiropractor

Rehabilitation is the discipline focused on restoring a patient's functional abilities to pre-injury or pre-disease status. Functional abilities are defined as those activities in one's daily life, work, or sports and recreational activities that an individual participates in. Relevant impairments (e.g. strength, endurance, flexibility, motor control, etc.) are often intermediate goals of rehabilitation, but the final goal of successful care is return to participation in activities in which the patient was successful before the onset of the injury or disease. Essential to a rehabilitation approach is a focus on patient-centered outcomes such as independence and self-management or self-care skills.

Source: The American Chiropractic Association (ACA) and the ACA Council on Physiological Therapeutics [7/1/2006: new]

Effective Date 10/1/200

Specialization: Sports Physician

111NS0005X Sports Physician Chiropractor

A sports chiropractor is uniquely trained to provide care and treatment of injuries or illness resulting from sports and physical fitness activities. Doctors of Chiropractic with the Diplomate American Chiropractic Board of Sports Physicians (DACBSP) or the Certified Chiropractic Sports Physician (CCSP), sport specialty certifications from the American Chiropractic Board of Sports Physicians, have advanced training in the assessment, management and rehabilitation of sports related injuries. Extremity care, rehabilitation and soft tissue procedures are common skills utilized by these doctors. The specialty training covers a broad spectrum from the pediatric athlete to professional and Olympic athletes, and everything in between, using a variety of techniques and modalities.

Source: American Chiropractic Board of Sports Physicians, 2009 [7/1/2009: definition added]

Effective Date 4/1/2002

Chiropractic Providers

Chiropractor

Specialization: Thermography

111NT0100X Thermography Chiropractor

Definition to come...

Effective Date 4/1/2002

Dental Providers

Advanced Practice Dental Therapist

125K00000X Advanced Practice Dental Therapist

An Advanced Practice Dental Therapist is:

(1) A dental therapist who has completed additional training beyond basic dental therapy education and provides dental services in accordance with state advanced practice dental therapist laws or statutes; or

(2) A dental hygienist with a graduate degree in advanced dental therapy prepared for independent and interdependent decision making and direct accountability for clinical judgment across the dental health care continuum.

The individual has been authorized by the relevant state board or a tribal entity to provide services under the remote supervision of a dentist. The functions of the advanced practice dental therapist vary based on the needs of the dentist, the educational preparation of the advanced practice dental therapist and state dental practice acts and regulations.

Source: Summarized from Minnesota Statute 150A.106. [7/1/2012: new]

Effective Date 10/1/201

Dental Assistant

126800000X Dental Assistant

An individual who may or may not have completed an accredited dental assisting education program and who aids the dentist in providing patient care services and performs other nonclinical duties in the dental office or other patient care facility. The scope of the patient care functions that may be legally delegated to the dental assistant varies based on the needs of the dentist the educational preparation of the dental assistant and state dental practice acts and regulations. Patient care services are provided under the supervision of a dentist. To avoid misleading the public, no occupational title other than dental assistant should be used to describe this dental auxiliary.

Source: Comprehensive Policy Statement on Dental Auxiliaries, American Dental Association

Effective Date 4/1/2002

Dental Providers

Dental Hygienist

124Q00000X Dental Hygienist

An individual who has completed an accredited dental hygiene education program, and an individual who has been licensed by a state board of dental examiners to provide preventive care services under the supervision of a dentist. Functions that may be legally delegated to the dental hygienist vary based on the needs of the dentist, the educational preparation of the dental hygienist and state dental practice acts and regulations, but always include, at a minimum, scaling and polishing the teeth. To avoid misleading the public, no occupational title other than dental hygienist should be used to describe this dental auxiliary.

Source: Comprehensive Policy Statement on Dental Auxiliaries, American Dental Association.

Effective Date 4/1/2002

Dental Laboratory Technician

126900000X Dental Laboratory Technician

An individual who has the skill and knowledge in the fabrication of dental appliances, prostheses and devices in accordance with a dentist's laboratory work authorization. To avoid misleading the public, no occupational title other than dental laboratory technician or certified dental technician (when appropriate) should be used to describe this auxiliary.

Source: Comprehensive Policy Statement on Dental Auxiliaries, American Dental Association.

Effective Date 4/1/2002

Dental Therapist

125J00000X Dental Therapist

A Dental Therapist is an individual who has completed an accredited or non-accredited dental therapy program and who has been authorized by the relevant state board or a tribal entity to provide services within the scope of their practice under the supervision of a dentist. Functions that may be delegated to the dental therapist vary based on the needs of the dentist, the educational preparation of the dental therapist and state dental practice acts and regulations.

Source: Summarized from Minnesota Statute 150A.105. [7/1/2012: new]

Effective Date 10/1/201

Dentist

122300000X Dentist

A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.), licensed by the state to practice dentistry, and practicing within the scope of that license. There is no difference between the two degrees: dentists who have a DMD or DDS have the same education. Universities have the prerogative to determine what degree is awarded. Both degrees use the same curriculum requirements set by the American Dental Association's Commission on Dental Accreditation. Generally, three or more years of undergraduate education plus four years of dental school is required to graduate and become a general dentist. State licensing boards accept either degree as equivalent, and both degrees allow licensed individuals to practice the same scope of general dentistry. Additional post-graduate training is required to become a dental specialist.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Dental Providers

Dentist

Specialization: Dental Public Health

1223D0001X Public Health Dentist

The science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice that serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Dentist Anesthesiologist

1223D0004X Dentist Anesthesiologist

A dentist who has successfully completed an accredited postdoctoral anesthesiology residency training program for dentists of two or more years duration, in accord with Commission on Dental Accreditation's Standards for Dental Anesthesiology Residency Programs, and/or meets the eligibility requirements for examination by the American Dental Board of Anesthesiology.

Source: The American Society of Dentist Anesthesiologists [1/1/2013: new]

Effective Date 4/1/2013

Specialization: Endodontics

1223E0200X Endodontist

The branch of dentistry that is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: General Practice

1223G0001X General Practice Dentistry

A general dentist is the primary dental care provider for patients of all ages. The general dentist is responsible for the diagnosis, treatment, management and overall coordination of services related to patients' oral health needs.

Source: Academy of General Dentistry

Effective Date 4/1/2002

Dental Providers

Dentist

Specialization: Oral and Maxillofacial Pathology

1223P0106X Oral and Maxillofacial Pathology Dentist

The specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral and maxillofacial pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Oral and Maxillofacial Radiology

1223X0008X Oral and Maxillofacial Radiology Dentist

The specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Oral and Maxillofacial Surgery

1223S0112X Oral and Maxillofacial Surgery (Dentist)

The specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Orofacial Pain

1223X2210X Orofacial Pain Dentist

A dentist who assesses, diagnoses, and treats patients with complex chronic orofacial pain and dysfunction disorders, oromotor and jaw behavior disorders, and chronic head/neck pain. The dentist has successfully completed an accredited postdoctoral orofacial pain residency training program for dentists of two or more years duration, in accord with the Commission on Dental Accreditation's Standards for Orofacial Pain Residency Programs, and/or meets the requirements for examination and board certification by the American Board of Orofacial Pain.

Source: American Academy of Orofacial Pain, http://www.aaop.org [7/1/2019: new]

Additional Resources: American Board of Orofacial Pain, http://www.abop.net

Effective Date 10/1/201

Dental Providers

Dentist

Specialization: Orthodontics and Dentofacial Orthopedics

1223X0400X Orthodontics and Dentofacial Orthopedic Dentist

That area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.

Effective Date 4/1/2002

Specialization: Pediatric Dentistry

1223P0221X Pediatric Dentist

An age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Periodontics

1223P0300X Periodontist

That specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Prosthodontics

1223P0700X Prosthodontist

That branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Denturist

122400000X Denturist

Definition to come.

Effective Date 4/1/2002

Dental Providers

Oral Medicinist

125Q00000X Oral Medicinist

A dentist with advanced training specializing in the recognition and treatment of oral conditions resulting from the interrelationship between oral disease and systemic health. The Oral Medicinist manages clinical and non-surgical treatment of non-dental pathologies affecting the oral and maxillofacial region, such as cancer, organ transplants, and acute and chronic pain. Activities include provision of interdisciplinary patient care in collaboration with medical specialists and other dentists in hospitals and outpatient medical clinics in the management of patients with complex medical conditions requiring multidisciplinary healthcare intervention.

Source: National Uniform Claim Committee [1/1/2015: new] Additional Resources: American Academy of Oral Medicine

Effective Date 4/1/2015

Dietary & Nutritional Service Providers

Dietary Manager

132700000X Dietary Manager

A dietary manager is a trained food services professional who is charged with maintaining cost/profit objectives, purchasing foods and services for the department and supervising staff.. Dietary managers are trained to understand the basic nutritional needs of clients and work in partnership with dietitians, who offer specialized nutritional expertise. The CDM certified dietary manager designation is an advanced professional credential awarded to dietary managers who have completed specific course work, have passed the national credentialing exams (including a sanitation and safety exam) and have applied for certification.

Effective Date 4/1/2002

Dietetic Technician, Registered

136A00000X Registered Dietetic Technician

A Dietetic Technician, Registered (DTR)/Nutrition and Dietetics Technician, Registered (NDTR) is an individual holding a nationally protected title issued by the Commission on Dietetic Registration (CDR) to qualified individuals who obtain an associate's degree or higher and successfully complete a sliding set of academic, examination, and practice requirements accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) or established by CDR, the nature of which are dependent upon the level of academic degree obtained. The scope of practice of the NDTR focuses on food, nutrition, and dietetics practice, as well as related services. NDTRs work under the supervision of a Registered Dietitian Nutritionist (RDN) when in direct patient/client nutrition care, and may work independently in providing general nutrition education to healthy populations. Patient/client populations include individuals receiving individualized care who have medical conditions or diseases, as well as at-risk individuals receiving personalized nutrition guidance as part of preventive health care.

Source: Academy of Nutrition and Dietetics Definition of Terms List, Current Version, https://www.eatrightpro.org/practice/quality-management/scope-of-practice [7/1/2019:modified definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2019

Dietary & Nutritional Service Providers

Dietitian, Registered

133V00000X Registered Dietitian

A Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN) is an individual uniquely trained in the science of nutrition and practice of dietetics to design and provide medical nutrition therapy (MNT) and other evidence-based applications of the Nutrition Care Process (NCP) that exemplify the profession's systematic approach to providing high quality nutrition care. Registered dietitians provide MNT for the purpose of disease prevention or management, or to treat or rehabilitate an illness, injury, or condition, with the use of specific, indicated physical and cognitive nutrition care services comprised of one or more of the following aspects of the NCP: nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention (e.g., nutrition counseling, therapeutic diet ordering, and nutrition education) and nutrition monitoring and evaluation.

Source: Academy of Nutrition and Dietetics Definition of Terms List , Current Version, https://www.eatrightpro.org/practice/quality-management/scope-of-practice [7/1/2019:modified definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2019

Specialization: Nutrition, Gerontological

133VN1101X Gerontological Nutrition Registered Dietitian

An individual who is a Specialist in Gerontological Nutrition and provides nutrition care to promote quality of life and optimal health for older adults across the continuum of care, including: acute care, post-acute care, primary care, long-term care, assisted living, home care, palliative care, community-based nutrition, food service, correctional facilities, and government programs. RDN who works indirectly with gerontological nutrition through roles in management, industry, education, and research.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/201

Specialization: Nutrition, Metabolic

133VN1006X Metabolic Nutrition Registered Dietitian

Definition to come...

Effective Date 4/1/2002

Specialization: Nutrition, Obesity and Weight Management

133VN1201X Obesity and Weight Management Nutrition Registered Dietitian

An individual who is a Board Certified Specialist for Obesity and Weight Management and educates, supports, and advocates for patients and clients to understand and manage their weight and associated risks through the use of nutritional, behavioral health, medical, surgical, pharmacotherapeutic, and exercise and physical activity interventions.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/201

Dietary & Nutritional Service Providers

Dietitian, Registered

Specialization: Nutrition, Oncology

133VN1301X Oncology Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Oncology Nutrition and provides direct nutrition care for individuals at risk for or diagnosed with cancer. RDNs working directly with individuals at risk for, or diagnosed with, any type of malignancy or pre-malignant condition, in a variety of settings (e.g. hospitals, clinics, cancer centers, hospices, public health), OR indirectly through roles in management, education, industry, and research practice linked specifically to oncology nutrition. RDN who works indirectly with oncology nutrition through roles in management, education, industry, and research.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/201

Specialization: Nutrition, Pediatric

133VN1004X Pediatric Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Pediatric Nutrition and applies evidence-based nutrition knowledge in providing medical nutrition therapy for pediatric patients. Specialists work directly with healthy and/or ill children (newborn up to 21 years of age) as well as children with special health care needs in a variety of settings (hospitals, community-based and/or family-centered programs, education programs, home, etc.), OR indirectly through management, care coordination, education, quality improvement, or research practice linked specifically to pediatric nutrition.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: definition added, source added]

Effective Date 4/1/2002 Last Modified Date 7/1/2019

Specialization: Nutrition, Pediatric Critical Care

133VN1401X Pediatric Critical Care Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Pediatric Critical Care Nutrition and applies evidence-based nutrition knowledge in providing medical nutrition therapy for critically ill infants, children and adolescents. Additional roles could include coordination, education, quality improvement, or research linked specifically to pediatric critical care nutrition.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/201

Specialization: Nutrition, Renal

133VN1005X Renal Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Renal Nutrition and works directly with adult and/or pediatric patients with acute kidney injury, chronic kidney disease (CKD) stages 1-5, or receiving renal replacement therapies (dialysis/transplant) in a variety of settings, OR works indirectly in management, education, or research practice linked specifically to renal nutrition. The specialist in renal/nephrology nutrition is responsible for nutrition assessment, diagnosis, intervention, monitoring, and evaluation.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: definition added, source added]

Effective Date 4/1/2002 Last Modified Date 7/1/2019

Dietary & Nutritional Service Providers

Dietitian, Registered

Specialization: Nutrition, Sports Dietetics

133VN1501X Sports Dietetics Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Sports Dietetics and applies evidence-based nutrition knowledge in exercise and sports. RDNs specializing in sports dietetics assess, educate, and counsel athletes and active individuals. They design, implement, and manage safe and effective nutrition strategies that enhance lifelong health, fitness, and optimal performance.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/201

Nutritionist

133N00000X Nutritionist

A specialist in adapting and applying food and nutrient knowledge to the solution of food and nutritional problems, the control of disease, and the promotion of health. Nutritionists perform research, instruct groups and individuals about nutritional requirements, and assist people in developing meal patterns that meet their nutritional needs; (2) A nutritionist is someone who has completed undergraduate and/or graduate training in the discipline of nutrition without necessarily meeting the academic and experience requirements to qualify for the Registered Dietitian designation.

Source: (1) Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Specialization: Nutrition, Education

133NN1002X Nutrition Education Nutritionist

Definition to come...

Effective Date 4/1/2002

Emergency Medical Service Providers

Emergency Medical Technician, Basic

146N00000X Basic Emergency Medical Technician

A Basic EMT is an individual trained and certified to perform basic life support treatment in medical emergencies based on individual state boards.

Sources: Tabers Medical Dictionary and Florida EMS Clearing House.

Effective Date 4/1/2002

Emergency Medical Service Providers

Emergency Medical Technician, Intermediate

146M00000X Intermediate Emergency Medical Technician

An Intermediate EMT is an individual trained and certified to perform intermediate life support treatment in medical emergencies based on individual state boards.

Sources: Tabers Medical Dictionary and Florida EMS Clearing House.

Effective Date 4/1/2002

Emergency Medical Technician, Paramedic

146L00000X Paramedic

An EMT, Paramedic is an individual trained and certified to perform advanced life support (ALS) in medical emergencies based on individual state boards.

Sources: Tabers Medical Dictionary and Florida EMS Clearing House.

Effective Date 4/1/2002

Personal Emergency Response Attendant

146D00000X Personal Emergency Response Attendant

Individuals that are specially trained to assist patients living at home with urgent/emergent situations. These individuals must be able to perform CPR and basic first aid and have sufficient counseling skills to allay fears and assist in working through processes necessary to resolve the crisis. Functions may include transportation to various facilities and businesses, contacting agencies to initiate remediation service or providing reassurance.

Effective Date 4/1/2002

Eye and Vision Services Providers

Optometrist

152W00000X Optometrist

Doctors of optometry (ODs) are the primary health care professionals for the eye. Optometrists examine, diagnose, treat, and manage diseases, injuries, and disorders of the visual system, the eye, and associated structures as well as identify related systemic conditions affecting the eye. An optometrist has completed pre-professional undergraduate education in a college or university and four years of professional education at a college of optometry, leading to the doctor of optometry (O.D.) degree. Some optometrists complete an optional residency in a specific area of practice. Optometrists are eye health care professionals state-licensed to diagnose and treat diseases and disorders of the eye and visual system.

Source: American Optometric Association (AOA), approved by the AOA's Board of Trustees, June 21, 2005. [7/1/2006: definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Eye and Vision Services Providers

Optometrist

Specialization: Corneal and Contact Management

152WC0802X Corneal and Contact Management Optometrist

The professional activities performed by an Optometrist related to the fitting of contact lenses to an eye, ongoing evaluation of the cornea's ability to sustain successful contact lens wear, and treatment of any external eye or corneal condition which can affect contact lens wear.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Low Vision Rehabilitation

152WL0500X Low Vision Rehabilitation Optometrist

Optometrists who specialize in low-vision care having training to assess visual function, prescribe low-vision devices, develop treatment plans, and recommend other vision rehabilitation services.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Occupational Vision

152WX0102X Occupational Vision Optometrist

Optometrists who work in Occupational Vision, the branch of environmental optometry, consider all aspects of the relationship between work and vision, visual performances, eye safety, and health.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Pediatrics

152WP0200X Pediatric Optometrist

Optometrists who work in Pediatrics are concerned with the prevention, development, diagnosis, and treatment of visual problems in children.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Sports Vision

152WS0006X Sports Vision Optometrist

An optometrist who offers services designed to care for unique vision care needs of athletes, which may include one of more of the following services: corrective vision care unique to a specific sporting environment; protective eyewear for the prevention of sports-related injuries; vision enhancement - which may include vision therapy and techniques to improve visual skills specific to the athlete's sport.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Eye and Vision Services Providers

Optometrist

Specialization: Vision Therapy

152WV0400X Vision Therapy Optometrist

Optometrists who specialize in vision therapy as a treatment process used to improve vision function. It includes a broad range of developmental and rehabilitative treatment programs individually prescribed to remediate specific sensory, motor and/or visual perceptual dysfunctions.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Technician/Technologist

156F00000X Technician/Technologist

A broad category grouping different kinds of technologists and technicians. See individual definitions.

Effective Date 4/1/2002

Specialization: Contact Lens

156FC0800X Contact Lens Technician/Technologist

An optician or other ancillary support staff person who, where authorized by state law and trained or certified to do so, may fit or dispense contact lenses to a patient based on the prescription of an optometrist or medical physician.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Contact Lens Fitter

156FC0801X Contact Lens Fitter

An optician or other ancillary support staff person who, where authorized by state law and trained or certified to do so, may fit or dispense contact lenses to a patient based on the prescription of an optometrist or medical physician.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Ocularist

156FX1700X Ocularist

Definition to come...

Effective Date 4/1/2002

Eye and Vision Services Providers

Technician/Technologist

Specialization: Ophthalmic

156FX1100X Ophthalmic Technician/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Ophthalmic Assistant

156FX1101X Ophthalmic Assistant

Definition to come...

Effective Date 4/1/2002

Specialization: Optician

156FX1800X Optician

Definition to come...

Effective Date 4/1/2002

Specialization: Optometric Assistant

156FX1201X Optometric Assistant Technician

Definition to come...

Effective Date 4/1/2002

Specialization: Optometric Technician

156FX1202X Optometric Technician

Definition to come...

Effective Date 4/1/2002

Specialization: Orthoptist

156FX1900X Orthoptist

Definition to come...

Effective Date 4/1/2002

Group

Multi-Specialty

193200000X Multi-Specialty Group

A business group of one or more individual practitioners, who practice with different areas of specialization.

[7/1/2003: new]

Effective Date 10/1/200

Single Specialty

193400000X Single Specialty Group

A business group of one or more individual practitioners, all of who practice with the same area of specialization.

[7/1/2003: new]

Effective Date 10/1/200

Nursing Service Providers

Licensed Practical Nurse

164W00000X Licensed Practical Nurse

An individual with post-high school vocational training and practical experience in the provision of nursing care at a level less than that required for certification as a Registered Nurse. Requirements for education, experience, licensure, and job responsibilities vary among the states.

Source: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Licensed Psychiatric Technician

167G00000X Licensed Psychiatric Technician

An individual licensed by the state board as a Psychiatric Technician based upon completion of a prescribed course of theory and clinical practice, with two thirds of the clinical practice time focused on mental and developmental disorders. The psychiatric technician practices under the direct supervision of a physician, psychologist, registered nurse or other professional to provide care to patients with mental disorders and developmental disabilities.

Effective Date 4/1/2002

Nursing Service Providers

Licensed Vocational Nurse

164X00000X Licensed Vocational Nurse

An individual with post-high school vocational training and practical experience in the provision of nursing care at a level less than that required for certification as a Registered Nurse. [An alternate term for licensed practical nurse arising from difference in occupational titles between states and post-high school training programs and institutions.] Requirements for education, experience, licensure, and job responsibilities vary among the states.

Source: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Registered Nurse

163W00000X Registered Nurse

(1) A registered nurse is a person qualified by graduation from an accredited nursing school (depending upon schooling, a registered nurse may receive either a diploma from a hospital program, an associate degree in nursing (A.D.N.) or a Bachelor of Science degree in nursing (B.S.N.), who is licensed or certified by the state, and is practicing within the scope of that license or certification. R.N.'s assist patient in recovering and maintaining their physical or mental health. They assist physicians during treatments and examinations and administer medications. (2) A provider who is trained and educated in a formal nursing education program at an accredited school of nursing, passes a national certification examination, and is licensed by the state to practice nursing. The individual provides nursing services to patients or clients in areas such as health promotion, disease prevention, acute and chronic care and restoration and maintenance of health across the life span.

Sources: (2) American Nurses Association, American Nurses Credentialing Center, 1996 Certification Catalogue, and Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Specialization: Addiction (Substance Use Disorder)

163WA0400X Addiction (Substance Use Disorder) Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Administrator

163WA2000X Administrator Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Ambulatory Care

163WP2201X Ambulatory Care Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Cardiac Rehabilitation

163WC3500X Cardiac Rehabilitation Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Case Management

163WC0400X Case Management Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: College Health

163WC1400X College Health Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Community Health

163WC1500X Community Health Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Continence Care

163WC2100X Continence Care Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Continuing Education/Staff Development

163WC1600X Continuing Education/Staff Development Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Critical Care Medicine

163WC0200X Critical Care Medicine Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Diabetes Educator

163WD0400X Diabetes Educator Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Dialysis, Peritoneal

163WD1100X Peritoneal Dialysis Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Emergency

163WE0003X Emergency Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Enterostomal Therapy

163WE0900X Enterostomal Therapy Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Flight

163WF0300X Flight Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Gastroenterology

163WG0100X Gastroenterology Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: General Practice

163WG0000X General Practice Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Gerontology

163WG0600X Gerontology Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Hemodialysis

163WH0500X Hemodialysis Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Home Health

163WH0200X Home Health Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Hospice

163WH1000X Hospice Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Infection Control

163WI0600X Infection Control Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Infusion Therapy

163WI0500X Infusion Therapy Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Lactation Consultant

163WL0100X Lactation Consultant (Registered Nurse)

Definition to come...

Effective Date 4/1/2002

Specialization: Maternal Newborn

163WM0102X Maternal Newborn Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Medical-Surgical

163WM0705X Medical-Surgical Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Neonatal Intensive Care

163WN0002X Neonatal Intensive Care Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Neonatal, Low-Risk

163WN0003X Low-Risk Neonatal Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Nephrology

163WN0300X Nephrology Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Neuroscience

163WN0800X Neuroscience Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Nurse Massage Therapist (NMT)

163WM1400X Nurse Massage Therapist (NMT)

Definition to come...

Effective Date 4/1/2002

Specialization: Nutrition Support

163WN1003X Nutrition Support Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Obstetric, High-Risk

163WX0002X High-Risk Obstetric Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Obstetric, Inpatient

163WX0003X Inpatient Obstetric Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Occupational Health

163WX0106X Occupational Health Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Oncology

163WX0200X Oncology Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Ophthalmic

163WX1100X Ophthalmic Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Orthopedic

163WX0800X Orthopedic Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Ostomy Care

163WX1500X Ostomy Care Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Otorhinolaryngology & Head-Neck

163WX0601X Otorhinolaryngology & Head-Neck Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Pain Management

163WP0000X Pain Management Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Pediatric Oncology

163WP0218X Pediatric Oncology Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Pediatrics

163WP0200X Pediatric Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Perinatal

163WP1700X Perinatal Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Plastic Surgery

163WS0121X Plastic Surgery Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health

163WP0808X Psychiatric/Mental Health Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Adult

163WP0809X Adult Psychiatric/Mental Health Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Child & Adolescent

163WP0807X Child & Adolescent Psychiatric/Mental Health Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Registered Nurse First Assistant

163WR0006X Registered Nurse First Assistant

A perioperative registered nurse who works in collaboration with the surgeon and other health care team members to achieve optimal outcomes. The RNFA has acquired the necessary knowledge, judgment, and skills specific to the expanded role of RNFA clinical practice. Intraoperatively, the RNFA assists the surgeon.

Source: AORN Official Statement on RNFAs ratified by the AORN House of Delegates in 2004. [7/1/2006: new]

Effective Date 10/1/200

Specialization: Rehabilitation

163WR0400X Rehabilitation Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Reproductive Endocrinology/Infertility

163WR1000X Reproductive Endocrinology/Infertility Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: School

163WS0200X School Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Urology

163WU0100X Urology Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Women's Health Care, Ambulatory

163WW0101X Ambulatory Women's Health Care Registered Nurse

Definition to come...

Effective Date 4/1/2002

Specialization: Wound Care

163WW0000X Wound Care Registered Nurse

Definition to come...

Effective Date 4/1/2002

Nursing Service Related Providers

Adult Companion

372600000X Adult Companion

An individual who provides supervision, socialization, and non-medical care to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. These services are provided in accordance with a therapeutic goal in the plan of care.

[7/1/2003: new]

Effective Date 10/1/200

Chore Provider

372500000X Chore Provider

An individual who provides home maintenance services required to sustain a safe, sanitary living environment for individuals who because of age or disabilities is unable to perform the activities. These services include heavy household chores such as washing floors, windows, and walls; tacking down loose rugs and tiles; and moving heavy items of furniture in order to provide safe access and egress.

[7/1/2003: new]

Effective Date 10/1/200

Day Training/Habilitation Specialist

373H00000X Day Training/Habilitation Specialist

Individuals experienced or trained in working with developmentally disabled individuals who need assistance in acquiring and maintaining life skills that enable them to cope more effectively with the demands of independent living.

Effective Date 4/1/2002

Doula

374J00000X Doula

Doulas work in a variety of settings and have been trained to provide physical, emotional, and informational support to a mother before, during, and just after birth and/or provide emotional and practical support to a mother during the postpartum period.

Source: National Uniform Claim Committee, 2009 [7/1/2009: new]

Effective Date 10/1/200

Home Health Aide

374U00000X Home Health Aide

A person trained to assist public health nurses, home health nurses, and other health professionals in the bedside care of patients in their homes.

Source: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Nursing Service Related Providers

Homemaker

376J00000X Homemaker

An individual who provides general household activities such as meal preparation, laundry, and light housekeeping, when the individual regularly responsible for these activities is temporarily absent or unable to provide for himself. Homemakers must meet the state defined training standards.

[7/1/2003: definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2003

Nurse's Aide

376K00000X Nurse's Aide

(1) An unlicensed individual who is trained to function in an assistive role to the licensed nurse in the provision of patient/client activities as delegated by the nurse; (2) An individual trained (either on-the-job or through a formal course generally of less than one year) and experienced in performing patient or client-care nursing tasks that do not require the skills of a specialist, technician, or professional. Examples of tasks performed by nurses aides include changing clothes, diapers, and beds; assisting patients to perform exercises or personal hygiene tasks, and supporting communication or social interaction. Specific education and credentials are not required for this work.

Source: (1) American Nurses Association, Registered Professional Nurses and Unlicensed Personnel, 2nd ed., 1996; (2) Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Nursing Home Administrator

376G00000X Nursing Home Administrator

An individual, often licensed by the state, who is responsible for the management of a nursing home.

Source: Lexikon: Dictionary of Health Care Terms, Organizations, and Acronyms for the Era of Reform, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, 1994, p. 552.

Effective Date 4/1/2002

Religious Nonmedical Nursing Personnel

374T00000X Religious Nonmedical Nursing Personnel

Religious nonmedical nursing personnel are experienced in caring for the physical needs of nonmedical patients. For example, caring for the physical needs such as assistance with activities of daily living; assistance with moving, positioning, and ambulation; nutritional needs; and comfort and support measures.

Source: Centers for Medicare & Medicaid Services [7/1/2009: title modified, definition modified] Additional Resources: www.cms.hhs.gov/CertificationandComplianc/19_RNHCIs.asp 2005 Code of Federal Regulations, Title 42, Chapter IV, Part 403, Subpart G, 403.702 Definitions and Terms

Effective Date 4/1/2002

Nursing Service Related Providers

Religious Nonmedical Practitioner

374K00000X Religious Nonmedical Practitioner

A religious nonmedical practitioner offers spiritually-based care. Services may be rendered in an office, home, or care facility or by phone, email, or written correspondence.

Source: National Uniform Claim Committee , 2009 [7/1/2009: new]

Effective Date 10/1/200

Technician

374700000X Technician

(1) A person with specialized training in a narrow field of expertise whose occupation requires training and is skilled in specific technical processes and procedures. (2) An individual having special skill or practical knowledge in an area, such as operation and maintenance of equipment or performance of laboratory procedures involving biochemical analyses. Special technical qualifications are normally required, though an increasing number or technicians also possess university degrees in science, and occasionally doctorate degrees. The distinction between technician and technologist in the health care field is not always clear.

Sources: (1) Rhea, Ott, and Shafritz, The Facts on File Dictionary of Health Care Management, New York: Facts on File Publications, 1988; Dorland's Illustrated Medical Dictionary, 26th Edition, Philadelphia: W.B. Saunders Company, 1981 and Webster's II New Riverside University Dictionary, Boston: Riverside Publishing Company, 1984. (2)) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 776.

Effective Date 4/1/2002

Specialization: Attendant Care Provider

3747A0650X Attendant Care Provider

An individual who provides hands-on care, of both a supportive and health related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Personal Care Attendant

3747P1801X Personal Care Attendant

An individual who provides assistance with eating, bathing, dressing, personal hygiene, activities of daily living as specified in the plan of care. Services which are incidental to the care furnished, or essential to the health and welfare of the individual may also be provided. Personal care providers must meet state defined training and certification standards

[7/1/2003: definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2003

Other Service Providers

Acupuncturist

171100000X Acupuncturist

An acupuncturist is a person who performs ancient therapy for alleviation of pain, anesthesia and treatment of some diseases. Acupuncturists use long, fine needles inserted into specific points in order to treat painful conditions or produce anesthesia.

Effective Date 4/1/2002

Case Manager/Care Coordinator

171M00000X Case Manager/Care Coordinator

A person who provides case management services and assists an individual in gaining access to needed medical, social, educational, and/or other services. The person has the ability to provide an assessment and review of completed plan of care on a periodic basis. This person is also able to take collaborative action to coordinate the services with other providers and monitor the enrollee's progress toward the cost-effective achievement of objectives specified in the plan of care. Credentials may vary from an experience in the fields of psychology, social work, rehabilitation, nursing or a closely related human service field, to a related Assoc of Arts Degree or to nursing credentials. Some states may require certification in case management.

Source: CMS State Medicaid Manual Section 4442.3 [7/1/2006: new]

Effective Date 10/1/200

Clinical Ethicist

174V00000X Clinical Ethicist

A clinical ethicist has been trained in bioethics and ethics case consultation. The clinical ethicist addresses medical-ethical dilemmas arising in clinical practice, such as end-of-life care, refusal of treatment, and futility of care; assists patients and health care providers with medical decision-making; and provides ethics education for patients and families.

Source: National Uniform Claim Committee [1/1/2011: new]

Effective Date 4/1/2011

Other Service Providers

Community Health Worker

172V00000X Community Health Worker

Community health workers (CHW) are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as), outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening. Some examples of these practitioners are Community Health Aides or Practitioners established under 25 USC 1616 (l) under HHS, Indian Health Service, Public Health Service.

Source: Health Resources and Services Administration, US Department of Health and Human Services - National Workforce Study on Community Health Workers, March, 2007. [7/1/2007: new] http://bhpr.hrsa.gov/healthworkforce/chw/

Effective Date 10/1/200

Contractor

171W00000X Contractor

A person who contracts to supply certain materials or do certain work for a stipulated sum; esp., one whose business is contracting work in any of the building trades. For purposes of the taxonomy, a person who contracts to complete home repairs or modifications to accommodate a health condition (e.g. wheelchair ramp, kitchen counter lowering).

Source: Websters New World Dictionary of the American Language, Second College Edition, William Collins + World Publishing Co., Inc., New York: 1974, p. 308

Effective Date 4/1/2002

Specialization: Home Modifications

171WH0202X Home Modifications Contractor

Definition to come...

Effective Date 4/1/2002

Specialization: Vehicle Modifications

171WV0202X Vehicle Modifications Contractor

A contractor who makes modifications to private vehicles to accommodate a health condition.

Effective Date 4/1/2002

Other Service Providers

Driver

172A00000X Driver

A person employed to operate a motor vehicle as a carrier of persons or property.

Effective Date 4/1/2002

Funeral Director

176P00000X Funeral Director

A person, usually an embalmer, whose business is to arrange for the burial or cremation of the dead and to assist at the funeral rites.

Source: Joint Commission on Accreditation of Healthcare Organizations, Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, Oakbrook Terrace, IL: 1994, p. 323

Effective Date 4/1/2002

Genetic Counselor, MS

170300000X Genetic Counselor (M.S.)

A masters trained health care provider who collects and interprets genetic family histories; assesses the risk of disease occurrence or recurrence; identifies interventions to manage or ameliorate disease risk; educates about inheritance, testing, management, prevention, ethical issues, resources, and research; and counsels to promote informed choices and adaptation. Certification was established in 1993 by the American Board of Genetic Counseling and prior to that by the American Board of Medical Genetics. Requirements for experience, licensure, and job responsibilities vary among the states.

Source: National Society of Genetic Counselors [7/1/2005: new]

Effective Date 10/1/200

Health & Wellness Coach

171400000X Health & Wellness Coach

The Health & Wellness Coach is trained in motivational theories, strategies, and communication techniques, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being. Health and wellness coaching is a patient-centered approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach.

Source: National Board for Health & Wellness Coaching, www.nbhwc.org [1/1/2021: new]

Effective Date 4/1/2021

Other Service Providers

Health Educator

174H00000X Health Educator

Health educators work in a variety of settings providing education to individuals or groups of individuals on healthy behaviors, wellness, and health-related topics with the goal of preventing diseases and health problems. Health educators generally require a bachelor's degree and may receive additional training, such as through mentoring, internships, or volunteer work.

Source: National Uniform Claim Committee, 2009 [7/1/2009: new]

Effective Date 10/1/200

Homeopath

175L00000X Homeopath

A provider who is educated and trained in a system of therapeutics in which diseases are treated by drugs which are capable of producing in healthy persons symptoms like those of the disease to be treated. Treatment requires administering a drug in minute doses.

Source: Dorland's Illustrated Medical Dictionary. 26th edition. Philadelphia: W.B. Saunders Company, 1981.

Effective Date 4/1/2002

Interpreter

171R00000X Interpreter

An Interpreter is a person who translates oral communication between two or more people. This includes translating from one language to another or interpreting sign language. An interpreter is necessary for medical care when the patient does not speak the language of the health care provider or when the patient has a disability involving spoken language.

Source: National Medicaid EDI HIPAA NPI Sub Work Group [7/1/2006: new]

Effective Date 10/1/200

Lactation Consultant, Non-RN

174N00000X Lactation Consultant (Non-RN)

An individual trained to provide breastfeeding assistance services to both mothers and infants. Lactation Consultants are not required to be nurses and are trained through specific courses of education. The Lactation Consultant may have additional certification through a national or international organization.

Source: National Uniform Claim Committee [1/1/2011: new]

Effective Date 4/1/2011

Other Service Providers

Legal Medicine

173000000X Legal Medicine

The specialty areas of medicine concerned with matters of, and relations with, substantive law and legal institutions; such as the conduct of medical examinations at crime scenes, performance of autopsies, giving of expert medical testimony in judicial proceedings, medical treatment of inmates of penal institutions, the practice of trauma medicine in law enforcement settings, and other clinical practice and medical science applications in the fields of law, law enforcement, and corrections.

Source: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Lodging

177F00000X Lodging Provider

A public or privately owned facility providing overnight lodging to individuals traveling long distances or receiving prolonged outpatient medical services away from home.

Effective Date 4/1/2002

Meals

174200000X Meals Provider

A public or privately owned facility providing meals to individuals traveling long distances or receiving prolonged outpatient medical services away from home.

Source: SD DSS Non-Emergency Medical Transportation program Transportation Services [7/1/2010: new]

Effective Date 10/1/201

Mechanotherapist

172M00000X Mechanotherapist

A practitioner of mechanotherapy examines patients by verbal inquiry, examination of the musculoskeletal system by hand, and visual inspection and observation. In the treatment of patients, mechanotherapists employ the techniques of advised or supervised exercise; electrical neuromuscular stimulation; massage or manipulation; or air, water, heat, cold, sound, or infrared ray therapy.

Source: Summarized from Ohio Revised Code 4731.15 [1/1/2007: new]

Effective Date 4/1/2007

Other Service Providers

Medical Genetics, Ph.D. Medical Genetics

170100000X Ph.D. Medical Genetics

A medical geneticist works in association with a medical specialist, is affiliated with a clinical genetics program, and serves as a consultant to medical and dental specialists.

A general certificate was first issued by ABMS in 1982. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2002

Midwife

176B00000X Midwife

A Midwife is a trained professional with special expertise in supporting women to maintain a healthy pregnancy birth, offering expert individualized care, education, counseling, and support to a woman and her newborn throughout the childbearing cycle. A Midwife is a skilled and independent practitioner who has undergone formalized training. Midwives are not required to be nurses and may be trained via multiple routes of education (apprenticeship, workshop, formal classes, or programs, etc., usually a combination). The educational background requirements and licensing requirements vary by state. The Midwife may or may not be certified by a state or national organization.

Source: The National Uniform Claim Committee [7/1/2007: title changed, definition changed, source changed]

Effective Date 4/1/2002 Last Modified Date 7/1/2007

Midwife, Lay

175M00000X Lay Midwife

A person qualified by experience and limited specialized training to provide obstetric and neo-natal care in the management of women having normal pregnancy, labor and childbirth. The lay midwife is licensed in some states.

Effective Date 4/1/2002

Military Health Care Provider

171000000X Military Health Care Provider

Active duty military health care providers not otherwise classified who need to be separately identified for operational, clinical, or administrative processes.

[7/1/2005: new]

Effective Date 10/1/200

Other Service Providers

Military Health Care Provider

Specialization: Independent Duty Corpsman

1710I1002X Independent Duty Corpsman

A Navy Independent Duty Corpsman (IDC) is an active duty Sailor who has successfully completed one of the Navy's specific IDC training programs. IDCs are formally trained and educated to perform primary medical care and minor surgical services in a variety of health care and non-health care settings worldwide under indirect physician supervision. IDCs provide care to Department of Defense operational forces and other supporting forces such as contractors and foreign nationals.

Source: Bureau of Medicine and Surgery, Department of the Navy [7/1/2005: new]

Effective Date 10/1/200

Specialization: Independent Duty Medical Technicians

1710I1003X Independent Duty Medical Technicians

An Independent Duty Medical Technician (IDMT) is specially trained and educated to perform primary medical care, minor surgical services, and treatment of dental disorders for active duty military members in a variety of health care and non-health care settings worldwide under direct and indirect physician supervision. An IDMT may take medical histories, perform physical exams, order lab tests and x-rays, prescribe medications, and give immunizations. IDMTs work under the direct supervision of a physician preceptor when at home station and indirectly when assigned to a Mobile Aid Station, Mobile Medical Unit, remote site, or otherwise deployed specifically as an IDMT. An IDMT may be an experienced Aerospace Medical Service Technician who meets special task qualifications and is recommended for training by the Aerospace Medical Service Functional Manager at their Medical Treatment Facility. IDMTs maintain certification as Nationally Registered Emergency Medical Technicians and as Immunization Back-up Technicians.

Source: Air Force Surgeon General Office [7/1/2005: new]

Effective Date 10/1/200

Naprapath

172P00000X Naprapath

Naprapathy means a branch of medicine that focuses on the evaluation and treatment of neuron-muscular conditions. Doctors of naprapathy are connective tissue specialists. Education and training are defined through individual states' licensing/certification requirements.

Source: National Uniform Claim Committee [1/1/2007: new]

Effective Date 4/1/2007

Other Service Providers

Naturopath

175F00000X Naturopath

Diagnoses, treats, and cares for patients, using system of practice that bases treatment of physiological functions and abnormal conditions on natural laws governing human body: Utilizes physiological, psychological, and mechanical methods, such as air, water, light, heat, earth, phototherapy, food and herb therapy, psychotherapy, electrotherapy, physiotherapy, minor and orificial surgery, mechanotherapy, naturopathic corrections and manipulation, and natural methods or modalities, together with natural medicines, natural processed foods, and herbs and nature's remedies. Excludes major surgery, therapeutic use of x ray and radium, and use of drugs, except those assimilable substances containing elements or compounds which are components of body tissues and are physiologically compatible to body processes for maintenance of life.

Source: The Federal Dictionary of Occupational Titles, U.S. Department of Labor, Washington, D.C., section #079, 101-014 [7/1/2007: definition changed, source added]

Effective Date 4/1/2002 Last Modified Date 7/1/2007

Peer Specialist

175T00000X Peer Specialist

Individuals certified to perform peer support services through a training process defined by a government agency, such as the Department of Veterans Affairs or a state mental health department/certification/licensing authority.

Source: National Uniform Claim Committee [7/1/2014: new]

Effective Date 10/1/201

Prevention Professional

405300000X Prevention Professional

Prevention Professionals work in programs aimed to address specific patient needs, such as suicide prevention, violence prevention, alcohol avoidance, drug avoidance, and tobacco prevention. The goal of the program is to reduce the risk of relapse, injury, or re-injury of the patient. Prevention Professionals work in a variety of settings and provide appropriate case management, mediation, referral, and mentorship services. Individuals complete prevention professionals training for the population of patients with whom they work.

Source: National Uniform Claim Committee, 2015 [1/1/2016: new]

Effective Date 4/1/2016

Other Service Providers

Reflexologist

173C00000X Reflexologist

Reflexologists perform a non-invasive complementary modality involving thumb and finger techniques to apply alternating pressure to the reflexes within the reflex maps of the body located on the feet, hands, and outer ears. Reflexologists apply pressure to specific areas (feet, hands, and ears) to promote a response from an area far removed from the tissue stimulated via the nervous system and acupuncture meridians. Reflexologists are recommended to complete a minimum of 200 hours of education, typically including anatomy & physiology, Reflexology theory, body systems, zones, meridians & relaxation response, ethics, business standards, and supervised practicum.

Source: National Uniform Claim Committee (based on the American Reflexology Certification Board definition of Reflexology), 2007 [1/1/2008: new] Additional Resources: Foot and hand reflexology is a scientific art based on the premise that there are zones and reflex areas in the feet and hands which correspond to all body parts. The physical act of applying specific pressures using thumb, finger and hand techniques result in stress reduction which causes a physiological change in the body. Reflexology is a non-invasive, complementary modality involving thumb and finger techniques to apply alternating pressure to reflexes shown on reflex maps of the body located on the feet, hands, and outer ears. American Reflexology Certification Board, www.arcb.net/definiti.htm; Reflexology Association of America, www.reflexology-usa.org/standards.html

Effective Date 4/1/2008

Sleep Specialist, PhD

173F00000X Sleep Specialist (PhD)

Sleep medicine is a clinical specialty with a focus on clinical problems that require accurate diagnosis and treatment. The knowledge base of sleep medicine is derived from many disciplines including neuroanatomy, neurophysiology, respiratory physiology, pharmacology, psychology, psychiatry, neurology, general internal medicine, pulmonary medicine, and pediatrics as well as others.

Source: National Uniform Claim Committee (based on American Board of Sleep Medicine), 2007 [1/1/2008: new] Additional resources: www.absm.org

Effective Date 4/1/2008

Specialist

174400000X Specialist

An individual educated and trained in an applied knowledge discipline used in the performance of work at a level requiring knowledge and skills beyond or apart from that provided by a general education or liberal arts degree.

Source: Expanded from Webster's II New Riverside University Dictionary, Boston: Riverside Publishing Company, 1974.

Effective Date 4/1/2002

Other Service Providers

Specialist

Specialization: Graphics Designer

1744G0900X Graphics Designer

Definition to come...

Effective Date 4/1/2002

Specialization: Prosthetics Case Management

1744P3200X Prosthetics Case Management

Definition to come...

Effective Date 4/1/2002

Specialization: Research Data Abstracter/Coder

1744R1103X Research Study Abstracter/Coder

Definition to come...

Effective Date 4/1/2002

Specialization: Research Study

1744R1102X Research Study Specialist

Definition to come...

Effective Date 4/1/2002

Veterinarian

174M00000X Veterinarian

A doctor of veterinary medicine, trained and authorized to practice veterinarian medicine and surgery.

Source: Dorland's Illustrated Medical Dictionary. 28th edition. Philadelphia: W.B. Saunders Company, 1994, p. 1823

Effective Date 4/1/2002

Specialization: Medical Research

174MM1900X Medical Research Veterinarian

Definition to come...

Effective Date 4/1/2002

Pharmacy Service Providers

Pharmacist

183500000X Pharmacist

An individual licensed by the appropriate state regulatory agency to engage in the practice of pharmacy. The practice of pharmacy includes, but is not limited to, assessment, interpretation, evaluation, and implementation, initiation, monitoring or modification of medication and or medical orders; the compounding or dispensing of medication and or medical orders; participation in drug and device procurement, storage, and selection; drug administration; drug regimen reviews; drug or drug-related research; provision of patient education and the provision of those acts or services necessary to provide medication therapy management services in all areas of patient care.

Source: Adapted from National Association of Boards of Pharmacy Model State Pharmacy Act, Article 1, Section 104. [1/1/2006: definition modified, source modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2006

Specialization: Ambulatory Care

1835P2201X Ambulatory Care Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in the provision of integrated, accessible health care services by pharmacists and is accountable for addressing medication needs, developing sustained partnerships with patients, and practicing in the context of family and community.

Source: Board of Pharmacy Specialties, www.bpsweb.org [7/1/2015: new]

Effective Date 10/1/201

Specialization: Critical Care

1835C0205X Critical Care Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in the delivery of patient care services by pharmacists, as integral members of interprofessional teams, working to ensure the safe and effective use of medications in critically ill patients.

Source: Board of Pharmacy Specialties, www.bpsweb.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: General Practice

1835G0000X Deactivated - Pharmacist

[1/1/2006: marked inactive, use value 183500000X]

Effective Date 4/1/2002 Deactivation Date 3/31/2006

Specialization: Geriatric

1835G0303X Geriatric Pharmacist

A pharmacist who is certified in geriatric pharmacy practice is designated as a "Certified Geriatric Pharmacist" (CGP). To become certified, candidates are expected to be knowledgeable about principles of geriatric pharmacotherapy and the provision of pharmaceutical care to the elderly.

Source: Commission for Certification in Geriatric Pharmacy (www.ccgp.org) [7/1/2006: new]

Effective Date 10/1/200

Pharmacy Service Providers

Pharmacist

Specialization: Nuclear

1835N0905X Nuclear Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in procurement, compounding, quality control testing, dispensing, distribution, and monitoring of radiopharmaceuticals.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: modified title, added definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Nutrition Support

1835N1003X Nutrition Support Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in maintenance and/or restoration of optimal nutritional status, designing and modifying treatment according to patient needs.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Oncology

1835X0200X Oncology Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in developing, recommending, implementing, monitoring, and modifying pharmacotherapeutic plans to optimize outcomes in patients with malignant diseases.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: new]

Effective Date 10/1/200

Specialization: Pediatrics

1835P0200X Pediatric Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in the delivery of patient care services by pharmacists that ensures the safe and effective use of medications for all children from neonates through adolescents.

Source: Board of Pharmacy Specialties, www.bpsweb.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist

1835P0018X Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist

Pharmacist Clinician/Clinical Pharmacy Specialist is a pharmacist with additional training and an expanded scope of practice that may include prescriptive authority, therapeutic management, and disease management.

Source: National Uniform Claim Committee, 2007 [1/1/2008: new]

Effective Date 4/1/2008

Pharmacy Service Providers

Pharmacist

Specialization: Pharmacotherapy

1835P1200X Pharmacotherapy Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in optimizing pharmacotherapeutic care of patients, by developing, implementing, monitoring, and modifying complex treatment plans, providing advanced level education and consultation, and collaborating with other health professionals in the management of therapy.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: modified definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Psychiatric

1835P1300X Psychiatric Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in optimizing care of patients with psychiatric illness by assessing and monitoring patients, recognizing drug-induced problems, and recommending appropriate treatment plans.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: modified title, added definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Pharmacy Technician

183700000X Pharmacy Technician

A person who works under the direct supervision of a licensed pharmacist and performs many pharmacy-related functions that do not require the professional judgment of a pharmacist.

Source: Pharmacy Technician Certification Board, www.ptcb.org [1/1/2006: modified definition, modified source]

Effective Date 4/1/2002 Last Modified Date 1/1/2006

Physician Assistants & Advanced Practice Nursing Providers

Advanced Practice Midwife

367A00000X Advanced Practice Midwife

Midwifery practice as conducted by certified nurse-midwives (CNMs) and certified midwives (CMs) is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the post partum period, care of the newborn, and the family planning and gynecologic needs of women. The CNM and CM practice within a health care system that provides for consultation, collaborative management, or referral, as indicated by the health status of the client. CNMs and CMs practice in accord with the Standards for the Practice of Midwifery, as defined by the American College of Nurse-Midwives (ACNM).

Source: American College of Nurse-Midwives, 2008 [7/1/2008: title changed, definition changed, source changed] Additional Resources: American College of Nurse-Midwives www.acnm.org. The American Midwifery Certification Board, Inc. [AMCB, formerly the ACNM Certification Council, Inc. (ACC)] opened its national certification exam to non-nurse graduates of midwifery education programs and issued the first certified midwife (CM) credential in 1997. Certified midwives are educated to meet the same high standards that certified nurse-midwives must meet. These are the standards that every state in the U.S. has recognized as the legal basis for nurse-midwifery practice. All education programs for CMs, like CNMs, award a post-baccalaureate certificate or higher degree. CMs take the same AMCB certification exam as CNMs and study side by side with nurse-midwifery students in some education programs. As an organization, ACNM supports efforts to legally recognize CMs as qualified midwifery practitioners granted the same rights and responsibilities as CNMs.

Effective Date 4/1/2002

Anesthesiologist Assistant

367H00000X Anesthesiologist Assistant

An individual certified by the state to perform anesthesia services under the direct supervision of an anesthesiologist. Anesthesiologist Assistants are required to have a bachelor's degree with a premed curriculum prior to entering a two-year anesthesiology assistant program, which is focused upon the delivery and maintenance of anesthesia care as well as advanced patient monitoring techniques. An Anesthesiologist Assistant must work as a member of the anesthesia care team under the direction of a qualified Anesthesiologist.

Effective Date 4/1/2002

Clinical Nurse Specialist

364S00000X Clinical Nurse Specialist

A registered nurse who, through a graduate degree program in nursing, or through a formal post-basic education program or continuing education courses and clinical experience, is expert in a specialty area of nursing practice within one or more of the components of direct patient/client care, consultation, education, research and administration.

Sources: American Nurses Association, American Nurses Credentialing Center, 1996 Certification Catalogue and The Interagency Conference on Nursing Statistics.

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Acute Care

364SA2100X Acute Care Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Adult Health

364SA2200X Adult Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Chronic Care

364SC2300X Chronic Care Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Community Health/Public Health

364SC1501X Community Health/Public Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Critical Care Medicine

364SC0200X Critical Care Medicine Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Emergency

364SE0003X Emergency Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Ethics

364SE1400X Ethics Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Family Health

364SF0001X Family Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Gerontology

364SG0600X Gerontology Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Holistic

364SH1100X Holistic Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Home Health

364SH0200X Home Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Informatics

364SI0800X Informatics Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Long-Term Care

364SL0600X Long-Term Care Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Medical-Surgical

364SM0705X Medical-Surgical Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Neonatal

364SN0000X Neonatal Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Neuroscience

364SN0800X Neuroscience Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Occupational Health

364SX0106X Occupational Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Oncology

364SX0200X Oncology Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Oncology, Pediatrics

364SX0204X Pediatric Oncology Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Pediatrics

364SP0200X Pediatric Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Perinatal

364SP1700X Perinatal Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Perioperative

364SP2800X Perioperative Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health

364SP0808X Psychiatric/Mental Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Adult

364SP0809X Adult Psychiatric/Mental Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Psychiatric/Mental Health, Child & Adolescent

364SP0807X Child & Adolescent Psychiatric/Mental Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Child & Family

364SP0810X Child & Family Psychiatric/Mental Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Chronically Ill

364SP0811X Chronically Ill Psychiatric/Mental Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Community

364SP0812X Community Psychiatric/Mental Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Geropsychiatric

364SP0813X Geropsychiatric Psychiatric/Mental Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Rehabilitation

364SR0400X Rehabilitation Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: School

364SS0200X School Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Transplantation

364ST0500X Transplantation Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Women's Health

364SW0102X Women's Health Clinical Nurse Specialist

Definition to come...

Effective Date 4/1/2002

Nurse Anesthetist, Certified Registered

367500000X Certified Registered Nurse Anesthetist

(1) A licensed registered nurse with advanced specialty education in anesthesia who, in collaboration with appropriate health care professionals, provides preoperative, intraoperative, and postoperative care to patients and assists in management and resuscitation of critical patients in intensive care, coronary care, and emergency situations. Nurse anesthetists are certified following successful completion of credentials and state licensure review and a national examination directed by the Council on Certification of Nurse Anesthetists. (2) A registered nurse who is qualified by special training to administer anesthesia in collaboration with a physician or dentist and who can assist in the care of patients who are in critical condition.

Sources: (1) Council on Certification of Nurse Anesthetists, Park Ridge, IL, and Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988. (2) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 548.

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Nurse Practitioner

363L00000X Nurse Practitioner

(1) A registered nurse provider with a graduate degree in nursing prepared for advanced practice involving independent and interdependent decision making and direct accountability for clinical judgment across the health care continuum or in a certified specialty. (2) A registered nurse who has completed additional training beyond basic nursing education and who provides primary health care services in accordance with state nurse practice laws or statutes. Tasks performed by nurse practitioners vary with practice requirements mandated by geographic, political, economic, and social factors. Nurse practitioner specialists include, but are not limited to, family nurse practitioners, gerontological nurse practitioners, pediatric nurse practitioners, obstetric-gynecologic nurse practitioners, and school nurse practitioners.

Source: (1) American Nurses' Association, American Nurses Credentialing Center, 1996 Certification Catalogue. (2)) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 549.

Effective Date 4/1/2002

Specialization: Acute Care

363LA2100X Acute Care Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Adult Health

363LA2200X Adult Health Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Community Health

363LC1500X Community Health Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Critical Care Medicine

363LC0200X Critical Care Medicine Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Nurse Practitioner

Specialization: Family

363LF0000X Family Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Gerontology

363LG0600X Gerontology Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Neonatal

363LN0000X Neonatal Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Neonatal, Critical Care

363LN0005X Critical Care Neonatal Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Obstetrics & Gynecology

363LX0001X Obstetrics & Gynecology Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Occupational Health

363LX0106X Occupational Health Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Nurse Practitioner

Specialization: Pediatrics

363LP0200X Pediatric Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Pediatrics, Critical Care

363LP0222X Critical Care Pediatric Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Perinatal

363LP1700X Perinatal Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Primary Care

363LP2300X Primary Care Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health

363LP0808X Psychiatric/Mental Health Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: School

363LS0200X School Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Nurse Practitioner

Specialization: Women's Health

363LW0102X Women's Health Nurse Practitioner

Definition to come...

Effective Date 4/1/2002

Physician Assistant

363A00000X Physician Assistant

A physician assistant is a person who has successfully completed an accredited education program for physician assistant, is licensed by the state and is practicing within the scope of that license. Physician assistants are formally trained to perform many of the routine, time-consuming tasks a physician can do. In some states, they may prescribe medications. They take medical histories, perform physical exams, order lab tests and x-rays, and give inoculations. Most states require that they work under the supervision of a physician.

Effective Date 4/1/2002

Specialization: Medical

363AM0700X Medical Physician Assistant

Definition to come...

Effective Date 4/1/2002

Specialization: Surgical

363AS0400X Surgical Physician Assistant

Definition to come...

Effective Date 4/1/2002

Podiatric Medicine & Surgery Service Providers

Assistant, Podiatric

211D00000X Podiatric Assistant

An individual who assists a podiatrist in tasks, such as exposing and developing x-rays; taking and recording patient histories; assisting in biomechanical evaluations and negative castings; preparing and sterilizing instruments and equipment; providing the patient with postoperative instructions; applying surgical dressings; preparing the patient for treatment, padding, and strapping; and performing routine office procedures.

Source: (1) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 622.

Effective Date 4/1/2002

Podiatrist

213E00000X Podiatrist

A podiatrist is a person qualified by a Doctor of Podiatric Medicine (D.P.M.) degree, licensed by the state, and practicing within the scope of that license. Podiatrists diagnose and treat foot diseases and deformities. They perform medical, surgical and other operative procedures, prescribe corrective devices and prescribe and administer drugs and physical therapy.

Effective Date 4/1/2002

Specialization: Foot & Ankle Surgery

213ES0103X Foot & Ankle Surgery Podiatrist

Definition to come...

Effective Date 4/1/2002

Specialization: Foot Surgery

213ES0131X Foot Surgery Podiatrist

Definition to come...

Effective Date 4/1/2002

Specialization: General Practice

213EG0000X Deactivated - Podiatrist

[7/1/2006: marked inactive, use value 213E00000X]

Effective Date 4/1/2002 Deactivation Date 9/30/2006

Podiatric Medicine & Surgery Service Providers

Podiatrist

Specialization: Primary Podiatric Medicine

213EP1101X Primary Podiatric Medicine Podiatrist

Definition to come...

Effective Date 4/1/2002

Specialization: Public Medicine

213EP0504X Public Medicine Podiatrist

Definition to come...

Effective Date 4/1/2002

Specialization: Radiology

213ER0200X Radiology Podiatrist

Definition to come...

Effective Date 4/1/2002

Specialization: Sports Medicine

213ES0000X Sports Medicine Podiatrist

Definition to come...

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Anaplastologist

229N00000X Anaplastologist

An anaplastologist is a professional who creates prostheses for the face and body. Patients treated include those missing anatomy due to cancer, traumatic injury, or birth differences. Generally, there are no state licensing requirements for anaplastologists. Certification specific to anaplastology is provided through the Board for Certified Clinical Anaplastology (BCCA) with a credential title of Certified Clinical Anaplastologist (CCA).

Source: American Anaplastology Association, www.anaplastology.org. [7/1/2006: new]

Effective Date 10/1/200

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Art Therapist

221700000X Art Therapist

(1) An individual who uses art to achieve the therapeutic goals of symptom relief, emotional integration, and recovery from or adjustment to illness or disability. (2) An art therapist uses a form of treatment that enables patients with mental or physical disabilities to use art as a way of expressing and dealing with feelings and inner conflicts. (3) An individual who uses arts modalities and creative processes during intentional intervention in therapeutic, rehabilitative, community, or educational settings to foster health, communication, and expression; promote the integration of physical, emotional, cognitive, and social functioning; enhance self-awareness; and facilitate change.

Source: (1) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 107. (2) Art Therapy Program, Marymount College, Tarrytown, NY (3) National Coalition of Arts

Effective Date 4/1/2002

Clinical Exercise Physiologist

224Y00000X Clinical Exercise Physiologist

A Clinical Exercise Physiologist is a health care professional who is trained to work with patients with chronic disease where exercise training has been shown to be of therapeutic benefit, including but not limited to cardiovascular and pulmonary disease, and metabolic disorders.

Source: What is a Clinical Exercise Physiologist? Clinical Exercise Physiology Association (CEPA), CEPA Executive Board, 2008 [10/1/2011: new]

Effective Date 10/1/201

Dance Therapist

225600000X Dance Therapist

The dance therapist, sometimes called a movement therapist, focuses on rhythmic body movements as a medium of physical and psychological change. Dance therapy is practiced more often with mental health patients than with physically disabled patients. A master's degree is required by the American Dance Therapy Association to award the credentials Dance Therapist Registered (DTR).

Source: Joel A. DeLisa and Bruce M. Gans, Rehabilitation Medicine: Principles and Practice Second Edition, J.B. Lippincott Company, Philadelphia: 1993, p. 11

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Developmental Therapist

222Q00000X Developmental Therapist

A Developmental Therapist is a person qualified by completion of an approved program in Developmental Therapy and where applicable credentialed by the state and practicing within the scope of the credential, or credentialed by completion of education experiences as approved by the state and practicing within the scope of that credential or, where state credentialing does not exist, certified by the Board of the Developmental Therapy Association. A developmental therapist evaluates children's global development in order to identify areas of developmental delay whether arising from physiological, neurological, or environmental factors, or a combination of factors; and designs, implements, and modifies therapeutic interventions for the child and the family to promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction in order to maximize functional independence and developmental homeostasis, and improve the quality of life at home and in the community; and provides consultation for the parents and other professionals working with the family on global development.

Source: The Illinois Developmental Therapists Association [1/1/2007: new]

Effective Date 4/1/2007

Kinesiotherapist

226300000X Kinesiotherapist

A provider trained and educated in the applied science of medically prescribed therapeutic exercise, education and adapted physical activities designed to improve the quality of line and health of adults and children by developing physical fitness, increasing mobility and independence, and improving psychosocial behavior. The kinesiotherapist seeks a coach-player relationship in which he/she helps the patient/client reach the goal of becoming an independent, self-sustaining person. Kinesiotherapists, as compared with physical therapists, put more emphasis on geriatric care, reconditioning and fitness, and psychiatric care. A large percentage of kinesiotherapists practice in Veterans Administration hospitals.

Source: The Kinesiotherapy Association.

Effective Date 4/1/2002

Massage Therapist

225700000X Massage Therapist

An individual trained in the manipulation of tissues (as by rubbing, stroking, kneading, or tapping) with the hand or an instrument for remedial or hygienic purposes.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Mastectomy Fitter

224900000X Mastectomy Fitter

An individual trained in the fitting and adjusting of breast prostheses and management of post-mastectomy prostheses services.

Source: National Uniform Claim Committee [7/1/2010: new] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 10/1/201

Music Therapist

225A00000X Music Therapist

Music therapists use music interventions to assess clients' strengths and needs, develop goals, implement services, and evaluate and document progress for individuals of all ages. Music therapists facilitate changes in physical, cognitive, emotional, and/or psychosocial health.

Source: American Music Therapy Association

Effective Date 4/1/2002

Occupational Therapist

225X00000X Occupational Therapist

An occupational therapist is a person who has graduated from an entry-level occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) or predecessor organizations, or approved by the World Federation of Occupational Therapists (WFOT), or an equivalent international occupational therapy education program; has successfully completed a period of supervised fieldwork experience required by the occupational therapy program; has passed a nationally recognized entry-level examination for occupational therapists, and fulfills state requirements for licensure, certification, or registration. An occupational therapist provides interventions based on evaluation and which emphasize the therapeutic use of everyday life activities (i.e., occupations) with individuals or groups for the purpose of facilitating participation in roles and situations and in home, school, workplace, community and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and are provided to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapists address the physical, cognitive, psychosocial, sensory, and other aspects of occupational performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: definition changed, added source]

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Driving and Community Mobility

225XR0403X Driving and Community Mobility Occupational Therapist

Occupational therapists can optimize and prolong an older driver's ability to drive safely and ease the transition to other forms of transportation if driving cessation becomes necessary. By identifying strengths as well as physical or cognitive challenges, occupational therapists can evaluate an individual's overall ability to operate a vehicle safely and recommend assistive devices or behavioral changes to limit risks. Occupational therapy practitioners offer a continuum of services related to community mobility, from evaluation of driving performance, through counseling and support for lifestyle changes, to maintaining independence and quality of life.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: title changed, definition added, source added] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Driving & Community Mobility Occupational Therapist if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Older Driver

Effective Date 4/1/2002

Specialization: Environmental Modification

225XE0001X Environmental Modification Occupational Therapist

Occupational therapy practitioners are experts at identifying the cause of difficulties in performance of activities of daily living and instrumental activities of daily living. Occupational therapy practitioners evaluate the client, their environment, and their occupational performance in that environment, as well as make recommendations for products to improve the fit between the client, place, and activity. Occupational therapists can evaluate both the skills of the client and the environmental features that support or limit the performance of meaningful or necessary activities, thereby enhancing health, safety and well-being. Based on this assessment, they recommend modification and intervention strategies that improve the fit between the person and his or her environment.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for an Environmental Modification Occupational Therapist if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Home Modifications

Effective Date 10/1/200

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Ergonomics

225XE1200X Ergonomics Occupational Therapist

Definition to come...

Effective Date 4/1/2002

Specialization: Feeding, Eating & Swallowing

225XF0002X Feeding, Eating & Swallowing Occupational Therapist

Occupational therapists provide interventions to clients of all ages with feeding, eating and swallowing difficulties. Occupational therapists provide comprehensive rehabilitative, habilitative, and palliative dysphagia care, which includes collaborating with clients to provide individualized compensatory swallowing strategies, modified diet textures, adapted mealtime environments, enhanced feeding skills, preparatory exercises and positioning to clients, reinforcement of mealtime strategies to enhance and improve swallowing skills, and training to caregivers to enhance eating and feeding performance. Occupational therapists provide screening and in-depth clinical assessment which may include instrumental dysphagia assessments including videofluroscopy.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Feeding, Eating & Swallowing Occupational Therapist if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Specialized Knowledge and Skills Paper: Feeding, Eating and Swallowing in Occupational Therapy Practice, 2007; AOTA Fact Sheets: OT: A Vital Role in Dysphagia Care

Effective Date 10/1/200

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Gerontology

225XG0600X Gerontology Occupational Therapist

Occupational therapists work with older adults in virtually every setting: assisted living, wellness programs, hospitals, nursing homes, senior centers, clinics and in the home. Occupational therapists bring an understanding of the importance of participation and occupation for overall well-being to those who are experiencing disabling conditions related to aging. The primary overarching goal of occupational therapy services with this population is to maximize independence and participation, thereby enabling an older person to continue to live successfully in his or her chosen environment. Occupational therapists can help older adults by developing strategies to help or maintain safety and well-being, to assist with life transitions, and to compensate for challenges they experience in activities of daily living, instrumental activities of daily living, leisure participation, social participation, and productive activities.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary board certification for a Gerontology Occupational Therapist if the applicant meets the following requirements: <ul> Professional degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 5 years of practice as an occupational therapist. Minimum of 5,000 hours of experience as an occupational therapist in the certification area in the last 7 calendar years. Minimum of 500 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 5 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Senior Center and Assisted Living Facilities

Effective Date 10/1/200

Specialization: Hand

225XH1200X Hand Occupational Therapist

Definition to come...

Effective Date 4/1/2002

Specialization: Human Factors

225XH1300X Human Factors Occupational Therapist

Definition to come...

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Low Vision

225XL0004X Low Vision Occupational Therapist

Occupational therapists enable children and adults with visual impairment to engage in their chosen daily living activities safely and as independently as possible. This is accomplished by 1) teaching the person to use their remaining vision as efficiently as possible to complete activities; (2) modifying activities so that they can be completed with less vision; (3) training the person in use of adaptive equipment to compensate for vision loss, including high and low technology assistive devices; and (4) modifying the person's environment.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Low Vision Occupational Therapist if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Low Vision; OT Services for Individuals with Visual Impairments

Effective Date 10/1/200

Specialization: Mental Health

225XM0800X Mental Health Occupational Therapist

Occupational therapists provide treatment for people recovering from a mental or physical illness to regain their independence and stability and to engage in normal daily occupations (work, home, family life, school, leisure). Occupational therapists provide particular emphasis on interventions that result in improved quality of life and decrease hospitalization.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary board certification for a Mental Health Occupational Therapist if the applicant meets the following requirements: <ul> Professional degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 5 years of practice as an occupational therapist. Minimum of 5,000 hours of experience as an occupational therapist in the certification area in the last 7 calendar years. Minimum of 500 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 5 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Partial Hospitalization Programs and Consumer

Effective Date 10/1/200

Specialization: Neurorehabilitation

225XN1300X Neurorehabilitation Occupational Therapist

Definition to come...

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Pediatrics

225XP0200X Pediatric Occupational Therapist

Occupational therapists provide services to infants, toddlers and children who have or who are at risk for developmental delays or disabilities. Occupational therapy is concerned with a child's ability to participate in daily life activities or "occupations." Occupational therapists use their unique expertise to help children with social-emotional, physical, cognitive, communication, and adaptive behavioral challenges and to help children to be prepared for and perform important learning and school-related activities and to fulfill their rule as students. Through an understanding of the impact of disability, illness, and impairment on a child's development, plan, ability to learn new skills, and overall occupational performance, occupational therapists design interventions that promote healthy development, establish needed skills, and/or modify environments, all in support of participation in daily activities.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary board certification for a Pediatric Occupational Therapist if the applicant meets the following requirements: <ul> Professional degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 5 years of practice as an occupational therapist. Minimum of 5,000 hours of experience as an occupational therapist in the certification area in the last 7 calendar years. Minimum of 500 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 5 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Specialized Knowledge and Skills Paper: Occupational Therapy Practice in the Neonatal Intensive Care Unity (2006); AOTA Fact Sheets: Children and the Tsunami, OT for Children Birth to 3 Years of Age, OT's Role with Autism, OT in Educational Settings Under the Individuals with Disabilities Education Act, Transforming Caseload to Workload in School Based and Early Intervention OT Services, OT in Preschool Settings.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Physical Rehabilitation

225XP0019X Physical Rehabilitation Occupational Therapist

Occupational therapists are experts at helping people lead as independent a life as possible. Occupational therapists bring an understanding of the physical and psychological implications of illness and injury and their effects on peoples' ability to perform the tasks of daily living. Occupational therapists provide interventions that can aide a person in completing ADL and IADL tasks, such as dressing, bathing, preparing meals, and driving. They also may fabricate custom orthotics to improve function, evaluate the environment for safety hazards and recommend adaptations to remove those hazards, help a person compensate for cognitive changes, and build a persons' physical endurance and strength. Occupational therapists' knowledge of adapting tasks and modifying the environment to compensate for functional limitations is used to increase the involvement of clients and to promote safety and success.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary board certification for a Physical Rehabilitation Occupational Therapist if the applicant meets the following requirements: <ul> Professional degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 5 years of practice as an occupational therapist. Minimum of 5,000 hours of experience as an occupational therapist in the certification area in the last 7 calendar years. Minimum of 500 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 5 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Consumer Tip Sheets: Stroke, Hip

Effective Date 10/1/200

Occupational Therapy Assistant

224Z00000X Occupational Therapy Assistant

An occupational therapy assistant is a person who has graduated from an occupational therapy assistant program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) or predecessor organizations, has successfully completed a period of supervised fieldwork experience required by the accredited occupational therapy assistant program, has passed a nationally recognized entry-level examination for occupational therapy assistants, and fulfills state requirements for licensure, certification, or registration. An occupational therapy assistant provides interventions under the supervision of an occupational therapist which emphasize the therapeutic use of everyday life activities (i.e., occupations) with individuals or groups for the purpose of facilitating participation in roles and situations and in home, school, workplace, community and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and are provided to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy assistants address the physical, cognitive, psychosocial, sensory, and other aspects of occupational performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: definition changed, source changed]

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapy Assistant

Specialization: Driving and Community Mobility

224ZR0403X Driving and Community Mobility Occupational Therapy Assistant

Occupational therapy assistants contribute to the completion of an individualized occupational therapy driving and community mobility evaluation by administering delegated assessments and identifying findings that impact the client's occupational performance. Clients engage in the assessment and occupational profile process to customize the evaluation to their individual driving and community mobility needs. Occupational therapy assistants administer and continuously modify individualized in-vehicle and community mobility assessments within the naturalistic context of the community in response to the occupational performance and safety behaviors of the client. They also implement an individualized intervention plan, within the parameters established in collaboration with the occupational therapist that reflects the contexts of the client and meets his or her occupational performance and safety needs. Occupational therapy assistants address immediate and long-term implications of psychosocial issues related to compromised driving and community mobility throughout the occupational therapy process and makes recommendations to the occupational therapist for modification to service delivery.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Driving & Community Mobility Occupational Therapy Assistant if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Older Driver; AOTA Website: Specialty Certification

Effective Date 10/1/200

Specialization: Environmental Modification

224ZE0001X Environmental Modification Occupational Therapy Assistant

Occupational therapy assistants provide environmental modifications under the supervision of an occupational therapist. OTAs develop and implement an individualized occupational therapy environmental modification plan that reflects the relevant contexts of the client and relevant others and maximizes current and future occupational performance, safety, and participation of the client. Clients receive environmental modification recommendations and interventions that enable them to meet occupational performance and participation goals and that have adequate flexibility to accommodate for their future needs.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for an Environmental Modification Occupational Therapy Assistant if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. Fact Sheet: Home Modifications and OT, AOTA Website: Specialty Certifications

Effective Date 10/1/200

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapy Assistant

Specialization: Feeding, Eating & Swallowing

224ZF0002X Feeding, Eating & Swallowing Occupational Therapy Assistant

Occupational therapy assistants provide environmental modifications under the supervision of an occupational therapist. OTAs develop and implement an individualized occupational therapy environmental modification plan that reflects the relevant contexts of the client and relevant others and maximizes current and future occupational performance, safety, and participation of the client. Clients receive environmental modification recommendations and interventions that enable them to meet occupational performance and participation goals and that have adequate flexibility to accommodate for their future needs.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Feeding, Eating & Swallowing Occupational Therapy Assistant if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Website: Specialty Certifications; AOTA Specialized Knowledge and Skills Paper: Feeding, Eating and Swallowing in Occupational Therapy Practice, 2007; AOTA Fact Sheets: OT: A Vital Role in Dysphagia Care

Effective Date 10/1/200

Specialization: Low Vision

224ZL0004X Low Vision Occupational Therapy Assistant

Occupational therapy assistants contribute to the completion of an individualized occupational therapy low-vision evaluation under the direction and supervision of the occupational therapist to identify factors that may facilitate, compensate for, or inhibit use of vision in occupational performance. Clients are engaged in the identification of strengths, limitations, and goals as they relate to low vision to optimize independence and participation in desired occupations. Occupational therapy assistants also contribute to the development and implementation of an individualized occupational therapy low-vision intervention plan in collaboration with the occupational therapist, client, and relevant others that reflects the client's priorities for occupational performance.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Low Vision Occupational Therapy Assistant if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Low Vision; OT Services for Individuals with Visual Impairments

Effective Date 10/1/200

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Orthotic Fitter

225000000X Orthotic Fitter

An individual trained in the management of fitting prefabricated orthoses.

Source: National Uniform Claim Committee [1/1/2011: title modified, definition modfied] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 4/1/2002 Last Modified Date 1/1/2011

Orthotist

222Z00000X Orthotist

A health care professional who is specifically educated and trained to manage comprehensive orthotic patient care, including musculoskeletal and neuromuscular anomalies resulting from injuries or disease processes involving the lower extremity, upper extremity or spinal segment/s and positional deformation of the cranium. Orthotists assess specific patient needs, formulate an appropriate treatment plan, implement the treatment plan and provide follow-up care.

Source: American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. [7/1/2010: modified, 7/1/2013: modified] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 4/1/2002 Last Modified Date 7/1/2013

Pedorthist

224L00000X Pedorthist

An individual who is trained in the management and treatment of conditions of the foot, ankle, and lower extremities requiring fitting, fabricating, and adjusting of pedorthic devices.

Source: National Uniform Claim Committee [7/1/2010: new] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 10/1/201

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Physical Therapist

225100000X Physical Therapist

Physical therapists (PTs) are licensed health care professionals who diagnose and treat individuals of all ages, from newborns to the very oldest, who have medical problems or other health-related conditions that limit their abilities to move and perform functional activities in their daily lives. PTs examine each individual and develop a plan using treatment techniques to promote the ability to move, reduce pain, restore function, and prevent disability. In addition, PTs work with individuals to prevent the loss of mobility before it occurs by developing fitness- and wellness-oriented programs for healthier and more active lifestyles. PTs: 1.Diagnose and manage movement dysfunction and enhance physical and functional abilities. 2.Restore, maintain, and promote not only optimal physical function but optimal wellness and fitness and optimal quality of life as it relates to movement and health. 3.Prevent the onset, symptoms, and progression of impairments, functional limitations, and disabilities that may result from diseases, disorders, conditions, or injuries. 4.Treat conditions of the musculoskeletal, neuromuscular, cardiovascular, pulmonary, and/or integumentary systems. 5.Address the negative effects attributable to unique personal and environmental factors as they relate to human performance. 6.PTs provide care for people in a variety of settings, including hospitals, private practices, outpatient clinics, home health agencies, schools, sports and fitness facilities, work settings, and nursing homes. State licensure is required in each state in which a PT practices.

Source: American Physical Therapy Association [1/1/2020: definition modified] Additional resources: https://www.apta.org/PTCareers/RoleofaPT/

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Cardiopulmonary

2251C2600X Cardiopulmonary Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Cardiovascular & Pulmonary Physical Therapy, who has demonstrated specialized knowledge and skill in cardiovascular and pulmonary anatomy and physiology medicine, rehabilitation, critical care, and emergency and trauma.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Cardio.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Electrophysiology, Clinical

2251E1300X Clinical Electrophysiology Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Clinical Electrophysiologic Physical Therapy, who has demonstrated specialized knowledge and skill in electrophysiologic examinations and evaluations and encompasses both the professional and technical components of the observation, recording, analysis, and interpretation of bioelectric muscle and nerve potentials, detected by means of surface or needle electrodes, for the purpose of evaluating the integrity of the neuromuscular system. Electrophysiologic evaluations include, but are not limited to, electrodiagnostic testing, which includes clinical needle electromyography, motor and sensory nerve conduction studies, and other evoked potential procedures.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional Resources: https://www.apta.org/apta-and-you/leadership-and-governance/policies/electrophysiologic-examination-evaluation ; http://www.abpts.org/Certification/ClinicalElectrophysiology/

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Physical Therapist

Specialization: Ergonomics

2251E1200X Ergonomics Physical Therapist

A licensed physical therapist who has demonstrated specialized knowledge and skills pertaining to the workplace, occupational demands, prevention of work-related injury, management of the worker with job-related symptoms or participation restrictions, and provides individual, group or population level evaluation, intervention and consulting to enhance worker performance.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional Resources: www.apta.org

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Geriatrics

2251G0304X Geriatric Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Geriatric Physical Therapy, who has demonstrated specialized knowledge and skill in the comprehensive biopsychosocial assessment and evidence-based management of movement in aging adults. This includes, but is not limited to, specialized knowledge in and consideration of normal age-related changes and pathological manifestations across all systems; cognition and mental health; polypharmacy; fall risk mitigation; bone health; healthy and active aging, and socioeconomic and health policy issues affecting aging adults. The geriatric physical therapist is an integral part of the interdisciplinary geriatric team and serves as an advocate for the highest level of well-being for the older adult.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: www.apta.org

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Hand

2251H1200X Hand Physical Therapist

Definition to come...

Effective Date 4/1/2002

Specialization: Human Factors

2251H1300X Human Factors Physical Therapist

Definition to come...

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Physical Therapist

Specialization: Neurology

2251N0400X Neurology Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Neurologic Physical Therapy, who has demonstrated specialized knowledge and skill in neuroanatomy and neurophysiology, including knowledge of central, peripheral, and autonomic nervous systems in populations with and without neurologic conditions; motor control and movement sciences in populations with and without neurologic conditions; behavioral sciences, including psychology and neuropsychology, and psychiatry; and medical management and pharmacology.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Neurology.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Orthopedic

2251X0800X Orthopedic Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Orthopaedic Physical Therapy, who has demonstrated specialized knowledge and skill in human anatomy and physiology, movement science; pathology/pathophysiology, pain science, medical and surgical considerations, orthopaedic physical therapy theory and practice, and critical inquiry for evidence-based practice.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Orthopaedics.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Pediatrics

2251P0200X Pediatric Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Pediatric Physical Therapy, who has demonstrated specialized knowledge and skill in anatomy, histology, including embryonic development, genetics, biomechanics, neurological function, neuroscience, and pathology, behavioral sciences, and understanding of diseases or conditions that necessitate physical therapy care, that affect systems that in turn necessitate physical therapy care (comorbidities), and that influence the type of intervention that can be given.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Pediatrics.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Physical Therapist

Specialization: Sports

2251S0007X Sports Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Sports Physical Therapy, who has demonstrated specialized knowledge and skill in human anatomy and physiology, movement science, pathology and pathophysiology, medical and surgical intervention, and health and wellness, as well as rehabilitation/return to sports, management of acute injury/illness, medical and surgical consideration, injury prevention, and sports performance enhancement.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Sports.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Physical Therapy Assistant

225200000X Physical Therapy Assistant

(1)Physical therapist assistants are skilled health care providers who are graduates of a physical therapist assistant associate degree program accredited by an agency recognized by the Secretary of the U.S. Department of Education or Council on Postsecondary Accreditation, who assists the physical therapist in providing physical therapy. The supervising physical therapist is directly responsible for the actions of the physical therapist assistant. The PTA performs physical therapy procedures and related tasks that have been selected and delegated by the supervising physical therapist. Duties of the PTA include assisting the physical therapist in implementing treatment programs, training patients in exercised and activities of daily living, conducting treatments, and reporting to the physical therapist on the patient's responses. In addition to direct patient care, the PTA may also perform such functions as patient transport, and clinic or equipment preparation and maintenance. Currently more than half of all states require PTAs to be licensed, registered or certified. (2) An individual who works under the supervision of a physical therapist to assist him or her in providing physical therapy services. A physical therapy assistant may, for instance, help patients follow an appropriate exercise program that will increase their strength, endurance, coordination, and range of motion and train patients to perform activities of daily life.

Source: (1) American Physical Therapy Association, P.O. Box 37257, Washington, D.C. 20013. (2) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL: 1994, p. 612

Effective Date 4/1/2002

Prosthetist

224P00000X Prosthetist

A health care professional who is specifically educated and trained to manage comprehensive prosthetic patient care for individuals who have sustained complete or partial limb loss or absence. Prosthetists assess specific patient needs, formulate an appropriate treatment plan, implement the treatment plan and provide follow-up care.

Source: American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. [7/1/2010: modified, 7/1/2013: modified] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 4/1/2002 Last Modified Date 7/1/2013

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Pulmonary Function Technologist

225B00000X Pulmonary Function Technologist

An individual who is trained and qualified to perform pulmonary diagnostic tests. In the course of conducting these tests, the Pulmonary Function Technologist is able to setup, calibrate, maintain, and ensure the quality assurance of the pulmonary function testing equipment. In the laboratory, clinical or patient care setting the technologist instructs patients, elicits cooperation, performs procedures, monitors patient response, and evaluates patient performance. Tests results are calculated, compared with predicted normal ranges, and evaluated for reliability. The technologist collects clinical history data and evaluates the clinical implications of the test results.

Effective Date 4/1/2002

Recreation Therapist

225800000X Recreation Therapist

A recreation therapist uses recreational activities for intervention in some physical, social or emotional behavior to bring about a desired change in that behavior and promote the growth and development of the patient.

Source: Joel A. DeLisa and Bruce M. Gans, Rehabilitation Medicine: Principles and Practice Second Edition, J.B. Lippincott Company, Philadelphia: 1993, p. 7

Effective Date 4/1/2002

Recreational Therapist Assistant

226000000X Recreational Therapist Assistant

Recreational Therapist Assistants work in support of or assistant to Recreational Therapists treating patients with disabilities, injuries, and illnesses. Recreational Therapist Assistants work in a variety of settings providing treatments using recreational activities, including games, sports, and crafts.

Source: National Uniform Claim Committee, 2015 [1/1/2016: new]

Effective Date 4/1/2016

Rehabilitation Counselor

225C00000X Rehabilitation Counselor

An individual trained and educated in a systematic process of assisting persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals assessment and appraisal, diagnosis and treatment planning, career (vocational) counseling, individual and group counseling interventions for adjustments to the medical and psychosocial impact of disability, case management, program evaluation and research, job analysis and placement counseling, and consultation on rehabilitation resources and technology. Certification generally requires a Master's degree with specialized courses in rehabilitation processes and technology.

Sources: Commission on Rehabilitation Counselor Certification and Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Rehabilitation Counselor

Specialization: Assistive Technology Practitioner

225CA2400X Assistive Technology Practitioner Rehabilitation Counselor

Definition to come...

Effective Date 4/1/2002

Specialization: Assistive Technology Supplier

225CA2500X Assistive Technology Supplier Rehabilitation Counselor

Definition to come...

Effective Date 4/1/2002

Specialization: Orientation and Mobility Training Provider

225CX0006X Orientation and Mobility Training Rehabilitation Counselor

Orientation and Mobility (O&M) specialists teach children and adults who have visual impairments the specific orientation skills used to find one's way in the environment and the mobility skills needed to travel safely and efficiently at home, school, work, and in the community. Instruction is usually provided one-on-one and can include skills such as how to use a long cane, the operation of low vision devices and electronic travel aids when appropriate, how to orient oneself to new environments, navigate public transportation systems, how to cross streets safely, and traveling by using hearing, remaining vision, and other senses. In addition, O&M Specialists help children to develop fundamental skills such as fine and gross motor skills, concept development and problem solving skills. Adult clients can also benefit from an O&M specialist evaluating their current use of travel-related skills, discussing their future goals, and helping them select a program of instruction that will allow them to reach their greatest travel potential.

Source: San Francisco State University Orientation and Mobility Program web site http://online.sfsu.edu/~mobility/ [7/1/2006: new]

Effective Date 10/1/200

Rehabilitation Practitioner

225400000X Rehabilitation Practitioner

A health care practitioner who trains or retrains individuals disabled by disease or injury to help them attain their maximum functional capacity.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Certified

227800000X Certified Respiratory Therapist

A Certified Respiratory Therapist (CRT) is a an entry level therapist who has passed a standardized written examination administered by the National Board for Respiratory Care (NBRC). CRTs provide diagnostic testing, therapeutics, monitoring, rehabilitation, and education to patients with disorders of the cardiopulmonary system. They provide these respiratory care services in all health care facilities and in the home. A CRT is a graduate of an associate degree program approved by the Commission on Accreditation of Allied Health Educational Programs (CAAHEP) and where applicable, is licensed by the state and is practicing within the scope of the license.

Effective Date 4/1/2002

Specialization: Critical Care

2278C0205X Critical Care Certified Respiratory Therapist

Respiratory emergencies are commonplace in the treatment of critical care patients. Included in the assessment measurements conducted by the respiratory therapist in the critical care settings are arterial blood gas puncture and analysis, intrarterial monitoring, bedside measurements of lung mechanics, hemodynamic monitoring, and inspired and expired gas measurements. This is coupled with the initiation and management of mechanical ventilation patients.

Effective Date 4/1/2002

Specialization: Educational

2278E1000X Educational Certified Respiratory Therapist

The focus of patient and family education activities is to promote knowledge of disease process, medical therapy, and self help. Respiratory therapists are uniquely qualified to provide this service in regard to cardiopulmonary diseases and injury.

Effective Date 4/1/2002

Specialization: Emergency Care

2278E0002X Emergency Care Certified Respiratory Therapist

The immediate availability of diagnostic and therapeutic cardiopulmonary services in the assessment and management of trauma victims, patients requiring airway management and others requiring emergency care.

Effective Date 4/1/2002

Specialization: General Care

2278G1100X General Care Certified Respiratory Therapist

This level of care includes diagnostics testing, therapeutics, monitoring, rehabilitation of patients with disorders of the cardiopulmonary system, as well as, education of the patient and family in regard to those disorders.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Certified

Specialization: Geriatric Care

2278G0305X Geriatric Care Certified Respiratory Therapist

Care of older patients who have age and/or disease related decremental pulmonary changes. Diagnosis and treatment is very important for this group since chronic lung disease is the major cause of morbidity and mortality among them. Furthermore, as this segment of the population increases, life expectancy is being extended.

Effective Date 4/1/2002

Specialization: Home Health

2278H0200X Home Health Certified Respiratory Therapist

Home care fosters individual responsibility for self-management of chronic respiratory conditions. It includes individualized assessment based plans of care service developed to promote safe, proper, and sustained use of prescribed respiratory therapy medications, equipment, and techniques in the home.

Effective Date 4/1/2002

Specialization: Neonatal/Pediatrics

2278P3900X Neonatal/Pediatric Certified Respiratory Therapist

The care and treatment of premature infants, newborns and children. This includes management of mechanical ventilation, assessment, diagnostics and generalized respiratory treatments.

Effective Date 4/1/2002

Specialization: Palliative/Hospice

2278P3800X Palliative/Hospice Certified Respiratory Therapist

A coordinated plan of care to help dying patients and their families handle the burden of terminal care. Effective secretion management and relief of dyspnea are paramount in caring for patients with end-stage pulmonary disease.

Effective Date 4/1/2002

Specialization: Patient Transport

2278P4000X Patient Transport Certified Respiratory Therapist

Transport respiratory therapist provide patient assessment, initiation of treatment modalities and continued monitoring of patient status of the critically ill and injured patients with special attention to advanced airway and ventilator management. The transport respiratory therapist knowledge and experience with complex neonatal, pediatric and adult patient care issues provides them with an expertise to assist with any patient care issue in a variety of transport modes.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Certified

Specialization: Pulmonary Diagnostics

2278P1004X Pulmonary Diagnostics Certified Respiratory Therapist

Included in the area of pulmonary diagnostics are the following; collection and analysis of physiological specimens, interpretation of physiological data, administration of tests of the cardiopulmonary system, and the conduct of both neurophysiological and sleep disorders studies.

Effective Date 4/1/2002

Specialization: Pulmonary Function Technologist

2278P1006X Pulmonary Function Technologist Certified Respiratory Therapist

An individual who is trained and qualified to perform pulmonary diagnostic tests. In the course of conducting these tests, the Pulmonary Function Technologist is able to setup, calibrate, maintain, and ensure the quality assurance of the pulmonary function testing equipment. In the laboratory, clinical or patient care setting the technologist instructs patients, elicits cooperation, performs procedures, monitors patient response, and evaluates patient performance. Tests results are calculated, compared with predicted normal ranges, and evaluated for reliability. The technologist collects clinical history data and evaluates the clinical implications of the test results.

Effective Date 4/1/2002

Specialization: Pulmonary Rehabilitation

2278P1005X Pulmonary Rehabilitation Certified Respiratory Therapist

The respiratory therapist can assist the chronic pulmonary patient in returning to an optimal role in society by providing an effective program. It includes bronchopulmonary drainage, exercise therapy, and patient education.

Effective Date 4/1/2002

Specialization: SNF/Subacute Care

2278S1500X SNF/Subacute Care Certified Respiratory Therapist

Care of residents in a long-term care environment. Respiratory modalities delivered include those similar in the general care and critical care areas but provided to less critical patients.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Registered

227900000X Registered Respiratory Therapist

A Registered Respiratory Therapist (RRT) is an advanced therapist who has passed standardized written and clinical simulation examinations administered by the National Board for Respiratory Care (NBRC). In addition, to the certified therapist (CRT) entry level skills, RRTs have advanced education and training in patient assessment, in the development and modification of patient care plans, and in assuring the appropriate utilization of respiratory care resources. An RRT is a graduate of an associate or baccalaureate degree producing educational programs approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and where applicable, is licensed by the state and is practicing within the scope of that license.

Effective Date 4/1/2002

Specialization: Critical Care

2279C0205X Critical Care Registered Respiratory Therapist

Respiratory emergencies are commonplace in the treatment of critical care patients. Included in the assessment measurements conducted by the respiratory therapist in the critical care settings are arterial blood gas puncture and analysis, intrarterial monitoring, bedside measurements of lung mechanics, hemodynamic monitoring, and inspired and expired gas measurements. This is coupled with the initiation and management of mechanical ventilation patients.

Effective Date 4/1/2002

Specialization: Educational

2279E1000X Educational Registered Respiratory Therapist

The focus of patient and family education activities is to promote knowledge of disease process, medical therapy, and self help. Respiratory therapists are uniquely qualified to provide this service in regard to cardiopulmonary diseases and injury.

Effective Date 4/1/2002

Specialization: Emergency Care

2279E0002X Emergency Care Registered Respiratory Therapist

The immediate availability of diagnostic and therapeutic cardiopulmonary services in the assessment and management of trauma victims, patients requiring airway management and others requiring emergency care.

Effective Date 4/1/2002

Specialization: General Care

2279G1100X General Care Registered Respiratory Therapist

This level of care includes diagnostics testing, therapeutics, monitoring, rehabilitation of patients with disorders of the cardiopulmonary system, as well as, education of the patient and family in regard to those disorders.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Registered

Specialization: Geriatric Care

2279G0305X Geriatric Care Registered Respiratory Therapist

Care of older patients who have age and/or disease related decremental pulmonary changes. Diagnosis and treatment is very important for this group since chronic lung disease is the major cause of morbidity and mortality among them. Furthermore, as this segment of the population increases, life expectancy is being extended.

Effective Date 4/1/2002

Specialization: Home Health

2279H0200X Home Health Registered Respiratory Therapist

Home care fosters individual responsibility for self-management of chronic respiratory conditions. It includes individualized assessment based plans of care service developed to promote safe, proper, and sustained use of prescribed respiratory therapy medications, equipment, and techniques in the home.

Effective Date 4/1/2002

Specialization: Neonatal/Pediatrics

2279P3900X Neonatal/Pediatric Registered Respiratory Therapist

The care and treatment of premature infants, newborns and children. This includes management of mechanical ventilation, assessment, diagnostics and generalized respiratory treatments.

Effective Date 4/1/2002

Specialization: Palliative/Hospice

2279P3800X Palliative/Hospice Registered Respiratory Therapist

A coordinated plan of care to help dying patients and their families handle the burden of terminal care. Effective secretion management and relief of dyspnea are paramount in caring for patients with end-stage pulmonary disease.

Effective Date 4/1/2002

Specialization: Patient Transport

2279P4000X Patient Transport Registered Respiratory Therapist

Transport respiratory therapist provide patient assessment, initiation of treatment modalities and continued monitoring of patient status of the critically ill and injured patients with special attention to advanced airway and ventilator management. The transport respiratory therapist knowledge and experience with complex neonatal, pediatric and adult patient care issues provides them with an expertise to assist with any patient care issue in a variety of transport modes.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Registered

Specialization: Pulmonary Diagnostics

2279P1004X Pulmonary Diagnostics Registered Respiratory Therapist

Included in the area of pulmonary diagnostics are the following; collection and analysis of physiological specimens, interpretation of physiological data, administration of tests of the cardiopulmonary system, and the conduct of both neurophysiological and sleep disorders studies.

Effective Date 4/1/2002

Specialization: Pulmonary Function Technologist

2279P1006X Pulmonary Function Technologist Registered Respiratory Therapist

An individual who is trained and qualified to perform pulmonary diagnostic tests. In the course of conducting these tests, the Pulmonary Function Technologist is able to setup, calibrate, maintain, and ensure the quality assurance of the pulmonary function testing equipment. In the laboratory, clinical or patient care setting the technologist instructs patients, elicits cooperation, performs procedures, monitors patient response, and evaluates patient performance. Tests results are calculated, compared with predicted normal ranges, and evaluated for reliability. The technologist collects clinical history data and evaluates the clinical implications of the test results.

Effective Date 4/1/2002

Specialization: Pulmonary Rehabilitation

2279P1005X Pulmonary Rehabilitation Registered Respiratory Therapist

The respiratory therapist can assist the chronic pulmonary patient in returning to an optimal role in society by providing an effective program. It includes bronchopulmonary drainage, exercise therapy, and patient education.

Effective Date 4/1/2002

Specialization: SNF/Subacute Care

2279S1500X SNF/Subacute Care Registered Respiratory Therapist

Care of residents in a long-term care environment. Respiratory modalities delivered include those similar in the general care and critical care areas but provided to less critical patients.

Effective Date 4/1/2002

Specialist/Technologist

225500000X Respiratory/Developmental/Rehabilitative Specialist/Technologist

General classification identifying individuals who are trained on a specific piece of equipment or technical procedure.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Specialist/Technologist

Specialization: Athletic Trainer

2255A2300X Athletic Trainer

Athletic trainers are allied health care professionals who work in consultation with or under the direction of physicians, and specialize in the prevention, assessment, treatment and rehabilitation of injuries and illnesses. Currently, the entry-level employment requirements are a bachelor's degree with a major in athletic training from an accredited university or college. A majority of athletic trainers hold advanced degrees. National board certification is generally required as a condition of state licensure and employment. Most states regulate athletic trainers, and they practice within the scope of that license or regulation. Clinical practice includes emergency care, rehabilitation, reconditioning, therapeutic exercise, wellness programs, exercise physiology, kinesiology, biomechanics, nutrition, psychology and health care administration.

Source: National Athletic Trainers' Association (www.NATA.org) [1/1/2006: modified definition, modified source]

Effective Date 4/1/2002 Last Modified Date 1/1/2006

Specialization: Rehabilitation, Blind

2255R0406X Blind Rehabilitation Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Speech, Language and Hearing Service Providers

Audiologist

231H00000X Audiologist

(1) A specialist in evaluation, habilitation and rehabilitation of those whose communication disorders center in whole or in part in hearing function. Audiologists are autonomous professionals who identify, assess, and manage disorders of the auditory, balance and other neural systems. Audiologists provide audiological (aural) rehabilitation to children and adults across the entire age span. Audiologists select, fit and dispense amplification systems such as hearing aids and related devices. (2) An audiologist is a person qualified by a master's degree in audiology, licensed by the state, where applicable, and practicing within the scope of that license. Audiologists evaluate and treat patients with impaired hearing. They plan, direct and conduct rehabilitative programs with audiotry substitutional devises (hearing aids) and other therapy.

Source: (1) American Speech-Language-Hearing Association, (1996, Spring) Scope of practice in Audiology, p. 2

Effective Date 4/1/2002

Speech, Language and Hearing Service Providers

Audiologist

Specialization: Assistive Technology Practitioner

231HA2400X Assistive Technology Practitioner Audiologist

Definition to come...

Effective Date 4/1/2002

Specialization: Assistive Technology Supplier

231HA2500X Assistive Technology Supplier Audiologist

Definition to come...

Effective Date 4/1/2002

Audiologist-Hearing Aid Fitter

237600000X Audiologist-Hearing Aid Fitter

An audiologist/hearing aid fitter is the professional who specializes in evaluating and treating people with hearing loss, conducts a wide variety of tests to determine the exact nature of an individual's hearing problem, presents a variety of treatment options to patients, dispenses and fits hearing aids, administers tests of balance to evaluate dizziness and provides hearing rehabilitation training. This classification should be used where individuals are licensed as "audiologist-hearing aid fitters" as opposed to states that license individuals as "audiologists".

Source: American Academy of Audiology, 1735 N. Lynn St, Suite 950, Arlington VA 22209, (800)AAA-2336)

Effective Date 4/1/2002

Hearing Instrument Specialist

237700000X Hearing Instrument Specialist

Individuals who test hearing for the selection, adaptation, fitting, adjusting, servicing, and sale of hearing aids. Hearing Instrument Specialist is a designation provided individuals who qualify by the National Hearing Aid Society

Effective Date 4/1/2002

Specialist/Technologist

235500000X Speech/Language/Hearing Specialist/Technologist

General classification identifying individuals who are trained on a specific piece of equipment or technical procedure.

Effective Date 4/1/2002

Speech, Language and Hearing Service Providers

Specialist/Technologist

Specialization: Audiology Assistant

2355A2700X Audiology Assistant

Definition to come...

Effective Date 4/1/2002

Specialization: Speech-Language Assistant

2355S0801X Speech-Language Assistant

Definition to come...

Effective Date 4/1/2002

Speech-Language Pathologist

235Z00000X Speech-Language Pathologist

The speech-language pathologist is the professional who engages in clinical services, prevention, advocacy, education, administration, and research in the areas of communication and swallowing across the life span from infancy through geriatrics. Speech-language pathologists address typical and atypical impairments and disorders related to communication and swallowing in the areas of speech sound production, resonance, voice, fluency, language (comprehension and expression), cognition, and feeding and swallowing.

"Scope of Practice in Speech-Language Pathology", American Speech-Language-Hearing Association, 2013.

Effective Date 4/1/2002 Last Modified Date 1/1/2014

Student, Health Care

Student in an Organized Health Care Education/Training Program

390200000X Student in an Organized Health Care Education/Training Program

An individual who is enrolled in an organized health care education/training program leading to a degree, certification, registration, and/or licensure to provide health care.

[1/1/2005: new]

Effective Date 4/1/2005

Technologists, Technicians & Other Technical Service Providers

Perfusionist

242T00000X Perfusionist

A perfusionist operates extracorporeal circulation and autotransfusion equipment during any medical situation where it is necessary to support or temporarily replace the patient's circulatory or respiratory function. The perfusionist is knowledgeable concerning the variety of equipment available to perform extracorporeal circulation functions and is responsible, in consultation with the physician, for selecting the appropriate equipment and techniques to be used.

Source: Health Professions Career and Education Directory, American Medical Association [1/1/2007: new]

Effective Date 4/1/2007

Radiologic Technologist

247100000X Radiologic Technologist

An individual who is trained and qualified in the art and science of both ionizing and non-ionizing radiation for the purposes of diagnostic medical imaging, interventional procedures and therapeutic treatment.

Effective Date 4/1/2002

Specialization: Bone Densitometry

2471B0102X Bone Densitometry Radiologic Technologist

Definition to come.

Effective Date 4/1/2002

Specialization: Cardiac-Interventional Technology

2471C1106X Cardiac-Interventional Technology Radiologic Technologist

Definition to come.

Effective Date 4/1/2002

Specialization: Cardiovascular-Interventional Technology

2471C1101X Cardiovascular-Interventional Technology Radiologic Technologist

Definition to come...

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Radiologic Technologist

Specialization: Computed Tomography

2471C3401X Computed Tomography Radiologic Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Magnetic Resonance Imaging

2471M1202X Magnetic Resonance Imaging Radiologic Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Mammography

2471M2300X Mammography Radiologic Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Nuclear Medicine Technology

2471N0900X Nuclear Medicine Technology Radiologic Technologist

Definition to come.

Effective Date 4/1/2002

Specialization: Quality Management

2471Q0001X Quality Management Radiologic Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Radiation Therapy

2471R0002X Radiation Therapy Radiologic Technologist

Definition to come...

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Radiologic Technologist

Specialization: Radiography

2471C3402X Radiography Radiologic Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Sonography

2471S1302X Sonography Radiologic Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Vascular Sonography

2471V0105X Vascular Sonography Radiologic Technologist

Definition to come.

Effective Date 4/1/2002

Specialization: Vascular-Interventional Technology

2471V0106X Vascular-Interventional Technology Radiologic Technologist

Definition to come.

Effective Date 4/1/2002

Radiology Practitioner Assistant

243U00000X Radiology Practitioner Assistant

A Radiology Practitioner Assistant (RPA) is a health professional certified as a registered radiographer with the American Registry of Radiologic Technologists (ARRT) and, in addition, is credentialed to provide primary radiology health care with radiologist supervision. Radiology Practitioner Assistants are qualified by graduation from an educational program recognized by the Board of Directors of athe Certification Board for Radiology Practitioner Assistants (CBRPA) and certified by the CBRPA. Within the Radiologist/RPA relationship, Radiology Practitioner Assistants exercise autonomy in decision making in the role of a primary caregiver with regard to patient assessment, patient management and in providing a broad range of radiology diagnostic and interventional services. The clinical role of the Radiology Practitioner Assistant includes primary and specialty care in radiology practice settings in rural and urban areas.

Source: Certification Board of Radiology Practitioner Assistants [7/1/2008: new] Additional Resources: www.cbrpa.org

Effective Date 10/1/200

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist Cardiovascular

246X00000X Cardiovascular Specialist/Technologist

An allied health professional who performs diagnostic examinations at the request or direction of a physician in one or more of the following three areas: invasive cardiology, noninvasive cardiology, and noninvasive peripheral vascular study. Cardiovascular technologists are one type of allied health professional for which the Committee on Allied Health Education and Accreditation has accredited education programs

Source: (1) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 159.

Effective Date 4/1/2002

Specialization: Cardiovascular Invasive Specialist

246XC2901X Cardiovascular Invasive Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Sonography

246XS1301X Sonography Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Vascular Specialist

246XC2903X Vascular Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialist/Technologist, Health Information

246Y00000X Health Information Specialist/Technologist

An individual with a high school diploma, on-the-job experience and coding education from seminars or college classes who passes a national certification examination in either inpatient and outpatient facility services coding, or physician services coding.

Source: American Health Information Management Association, Chicago, IL, 1996.

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Health Information

Specialization: Coding Specialist, Hospital Based

246YC3301X Hospital Based Coding Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Coding Specialist, Physician Office Based

246YC3302X Physician Office Based Coding Specialist

Definition to come...

Effective Date 4/1/2002

Specialization: Registered Record Administrator

246YR1600X Registered Record Administrator

Definition to come...

Effective Date 4/1/2002

Specialist/Technologist, Other

246Z00000X Other Specialist/Technologist

General classification identifying individuals trained on specific equipment and technical procedures in one of a collection of miscellaneous healthcare disciplines.

Effective Date 4/1/2002

Specialization: Art, Medical

246ZA2600X Medical Art Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Biochemist

246ZB0500X Biochemist

Definition to come...

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Other

Specialization: Biomedical Engineering

246ZB0301X Biomedical Engineer

Definition to come...

Effective Date 4/1/2002

Specialization: Biomedical Photographer

246ZB0302X Biomedical Photographer

Definition to come...

Effective Date 4/1/2002

Specialization: Biostatistician

246ZB0600X Biostatiscian

Definition to come...

Effective Date 4/1/2002

Specialization: EEG

246ZE0500X EEG Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Electroneurodiagnostic

246ZE0600X Electroneurodiagnostic Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Geneticist, Medical (PhD)

246ZG1000X Medical Geneticist (PhD) Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Other

Specialization: Graphics Methods

246ZG0701X Graphics Methods Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Illustration, Medical

246ZI1000X Medical Illustrator

Definition to come...

Effective Date 4/1/2002

Specialization: Nephrology

246ZN0300X Nephrology Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Orthopedic Assistant

246ZX2200X Orthopedic Assistant

An Orthopaedic Assistant is a person who has been trained to work as a physician extender in both clinical and surgical environments. An Orthopaedic Assistant assists with aspects of patient care as determined by the supervising surgeon including, but not limited to, obtaining patient history, assisting with examinations, injections, recording of office notes, and application/adjustment/removal of splints, casts, and other immobilization devices. Acting as a surgical first assistant for orthopaedic surgery cases includes providing aid in exposure, hemostasis, positioning of the patient, suturing and closure of body planes and skin, application of wound dressings or immobilization devices, and other technical functions that will help the surgeon carry out a safe operation with optimal results for the patient. An Orthopaedic Assistant may be licensed, registered, or certified depending on the state in which the individual practices.

Source: American Society of Orthopaedic Assistants (ASOA), 2014 [7/1/2014: new] Additional Resources: National Board for Certification of Orthopaedic Assistants

Effective Date 10/1/201

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Other

Specialization: Surgical Assistant

246ZC0007X Surgical Assistant

A surgical assistant is a skilled practitioner who has undergone formalized education and training as a surgical assistant. The surgical assistant performs surgical functions that include, but are not limited to: retracting, manipulating, suturing, clamping, cauterizing, litigating, and tying tissue; suctioning, irrigating and sponging; positioning the patient; closure of body planes and skin; and participating in hemostasis and volume replacement. Surgical assistants are certified and registered or licensed by the state, or, in states without licensure, certified as surgical assistants by completing appropriate education and training.

Source: Association of Surgical Assistants, 2014. [7/1/2007: new, 7/1/2014: title modified, definition modified] http://www.surgicalassistant.org/index.php/surgical-assisting Additional Resources: National Surgical Assistant Association, www.nsaa.net.

Effective Date 10/1/200 Last Modified Date 7/1/2014

Specialization: Surgical Technologist

246ZS0410X Surgical Technologist

Surgical technologists are allied health professionals, who are an integral part of the team of medical practitioners providing surgical care to patients. Surgical technologists work under the supervision of a surgeon to facilitate the safe and effective conduct of invasive surgical procedures, ensuring that the operating room environment is safe, that equipment functions properly, and that the operative procedure is conducted under conditions that maximize patient safety. Surgical technologists possess expertise in the theory and application of sterile and aseptic technique and combine the knowledge of human anatomy, surgical procedures, and implementation tools and technologies to facilitate a physician's performance of invasive therapeutic and diagnostic procedures.

Source: Association of Surgical Technologists, "Job Description: Surgical Technologist," 2014. [7/1/2014: code modified, title modified, definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2014

Specialist/Technologist, Pathology

246Q00000X Pathology Specialist/Technologist

(1) An individual educated and trained in clinical chemistry, microbiology or other biological sciences; and in gathering data on the blood, tissues, and fluids in the human body. Tests and procedures performed or supervised center on major areas of hematology, microbiology, immunohematology, immunology, clinical chemistry and urinalysis. Education and certification requires the equivalent of an associate degree and alternative combinations of accredited training and experience. (2) A specially trained individual who works under the direction of a pathologist, other physician, or scientist, and performs specialized chemical, microscopic, and bacteriological tests of human blood, tissue, and fluids. Also known as medical technologists, they perform and supervise tests and procedures in clinical chemistry, immunology, serology, bacteriology, hematology, parasitology, mycology, urinalysis, and blood banking. The work requires the correlation of test results with other data, interpretation of test findings, and exercise of independent judgment. The minimum educational requirement (for one of several certification programs in medical technology) is a baccalaureate degree with appropriate science course requirements, plus a twelve-month, structured, AMA approved medical technology program and an examination; or a baccalaureate degree with appropriate science course requirements and experience.

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Pathology

Specialization: Blood Banking

246QB0000X Blood Banking Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Chemistry

246QC1000X Chemistry Pathology Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Cytotechnology

246QC2700X Cytotechnology Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Hemapheresis Practitioner

246QH0401X Hemapheresis Practitioner

Definition to come...

Effective Date 4/1/2002

Specialization: Hematology

246QH0000X Hematology Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Histology

246QH0600X Histology Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Pathology

Specialization: Immunology

246QI0000X Immunology Pathology Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Laboratory Management

246QL0900X Laboratory Management Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Laboratory Management, Diplomate

246QL0901X Diplomate Laboratory Management Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Medical Technologist

246QM0706X Medical Technologist

Definition to come...

Effective Date 4/1/2002

Specialization: Microbiology

246QM0900X Microbiology Specialist/Technologist

Definition to come...

Effective Date 4/1/2002

Technician, Cardiology

246W00000X Cardiology Technician

An individual who has knowledge of specific techniques, instruments, and equipment required in performing specific cardiovascular/peripheral vascular diagnostic procedures.

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Technician, Health Information

247000000X Health Information Technician

Preferred term for an Accredited Record Technician who is an individual with an associate's degree from an accredited college or independent study program who is skilled in analyzing health information and in examination of medical records for accuracy, reporting of patient data for reimbursement, and creation of disease registries for researchers.

Source: American Health Information Management Association, Chicago, IL, 1996.

Effective Date 4/1/2002

Specialization: Assistant Record Technician

2470A2800X Assistant Health Information Record Technician

Definition to come...

Effective Date 4/1/2002

Technician, Other

247200000X Other Technician

A collective term for persons with specialized training in various narrow fields of expertise whose occupations require training and skills in specific technical processes and procedures; and where further classification is deemed unnecessary by the user.

Sources: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988; Dorland's Illustrated Medical Dictionary, 26th Edition. Philadelphia: W.B. Saunders Company, 1981; and Webster's II New Riverside University Dictionary. Boston: Riverside Publishing Company, 1984.

Effective Date 4/1/2002

Specialization: Biomedical Engineering

2472B0301X Biomedical Engineering Technician

Definition to come...

Effective Date 4/1/2002

Specialization: Darkroom

2472D0500X Darkroom Technician

Definition to come...

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Technician, Other

Specialization: EEG

2472E0500X EEG Technician

Definition to come...

Effective Date 4/1/2002

Specialization: Renal Dialysis

2472R0900X Renal Dialysis Technician

Definition to come...

Effective Date 4/1/2002

Specialization: Veterinary

2472V0600X Veterinary Technician

Definition to come...

Effective Date 4/1/2002

Technician, Pathology

246R00000X Pathology Technician

An individual with knowledge of specific techniques and instruments who performs all of the routine tests in a medical laboratory and who has the ability to discriminate between similar factors that directly affect procedures and results.

Effective Date 4/1/2002

Specialization: Clinical Laboratory Director, Non-physician

247ZC0005X Clinical Laboratory Director (Non-physician)

An individual who is state-licensed as a clinical laboratory director and meets the qualifications in the Clinical Laboratory Improvement Amendments of 1988 for non-physicians (non-MD/DO) as defined in the CFR 42 Part 493.1405.

Source: National Uniform Claim Committee [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Histology

246RH0600X Histology Technician

Definition to come...

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Technician, Pathology

Specialization: Medical Laboratory

246RM2200X Medical Laboratory Technician

Definition to come...

Effective Date 4/1/2002

Specialization: Phlebotomy

246RP1900X Phlebotomy Technician

Definition to come...

Effective Date 4/1/2002

Agencies

Case Management

251B00000X Case Management Agency

An organization that is responsible for providing case management services. The agency provides services which assist an individual in gaining access to needed medical, social, educational, and/or other services. Case management services may be used to locate, coordinate, and monitor necessary appropriate services. It may be used to encourage the use of cost-effective medical care by referrals to appropriate providers and to discourage over utilization of costly services. Case management may also serve to provide necessary coordination of non-medical services such as vocational rehabilitation, education, employment, when the services provided enable the individual to function at the highest level.

Source: CMS State Medicaid Manual Section 4442.3 [7/1/2006: definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Community/Behavioral Health

251S00000X Community/Behavioral Health Agency

A private or public agency usually under local government jurisdiction, responsible for assuring the delivery of community based mental health, intellectual disabilities, substance abuse and/or behavioral health services to individuals with those disabilities. Services may range from companion care, respite, transportation, community integration, crisis intervention and stabilization, supported employment, day support, prevocational services, residential support, therapeutic and supportive consultation, environmental modifications, intensive in-home therapy and day treatment, in addition to traditional mental health and behavioral treatment.

Source: National Medicaid EDI HIPAA NPI Sub Work Group [1/1/2007: modified definition, 1/1/2021: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2021

Agencies

Day Training, Developmentally Disabled Services

251C00000X Developmentally Disabled Services Day Training Agency

These agencies are authorized to provide day habilitation services to developmentally disabled individuals who live in their homes. The function of day habilitation is to assist an individual to acquire and maintain those life skills that enable the individual to cope more effectively with the demands of independent living. Also to raise the level of the individual's physical, mental, social, and vocational functioning.

Effective Date 4/1/2002

Early Intervention Provider Agency

252Y00000X Early Intervention Provider Agency

Early intervention services are an effective way to address the needs of infants and toddlers who have developmental delays or disabilities. The services are made available through a federal law known as the Individuals with Disabilities Education Act (IDEA). IDEA provides states and territories with specific requirements for providing early intervention services to infants and toddlers with special needs. In turn, each state and territory develops its own policies for carrying out IDEA and its requirements. Broadly speaking, early intervention services are special services for eligible infants and toddlers and their families. These services are designed to identify and meet children's needs in five developmental areas. These areas are: physical development, cognitive development, communication, social or emotional development, and adaptive development.

Source: National Dissemination Center for Children with Disabilities [7/1/2007: new] http://www.nichcy.org/pubs/parent/pa2txt.htm

Effective Date 10/1/200

Foster Care Agency

253J00000X Foster Care Agency

A Foster Care Agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Foster care settings include, but are not limited to, nonrelative foster family homes, relative foster homes (whether payments are being made or not), group homes, emergency shelters, residential facilities, and pre-adoptive homes.

Source: Code Of Federal Regulations, Title 45, Volume 4, Part 1355, Section 57 [1/1/2008: new]

Effective Date 4/1/2008

Agencies

Home Health

251E00000X Home Health Agency

A public agency or private organization, or a subdivision of such an agency or organization, that is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech-language pathology services, or occupational therapy, medical social services, and home health aide services. It has policies established by a professional group associated with the agency or organization (including at least one physician and one registered nurse) to govern the services and provides for supervision of such services by a physician or a registered nurse; maintains clinical records on all patients; is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards, where applicable; and meets other conditions found by the Secretary of Health and Human Services to be necessary for health and safety.

Source: CFR42 Chapter IV Part 484, http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html [7/1/2007: definition added, source added]

Effective Date 4/1/2002 Last Modified Date 7/1/2007

Home Infusion

251F00000X Home Infusion Agency

Definition to come...

Effective Date 4/1/2002

Hospice Care, Community Based

251G00000X Community Based Hospice Care Agency

Definition to come...

Effective Date 4/1/2002

In Home Supportive Care

253Z00000X In Home Supportive Care Agency

An In Home Supportive Care Agency provides services in the patient's home with the goal of enabling the patient to remain at home. The services provided may include personal care services such as hands-on assistance with activities of daily living (ADLs), e.g., eating, bathing, dressing, and bladder and bowel requirements; homemaker services and instrumental activities of daily living (IADLs), e.g., taking medications, shopping for groceries, laundry, housekeeping, and companionship; and/or supervision or cuing so that a person can perform tasks themselves.

Source: National Uniform Claim Committee, 2008 [7/1/2008: new]

Effective Date 10/1/200

Agencies

Local Education Agency (LEA)

251300000X Local Education Agency (LEA)

The term local education agency means a public board of education or other public authority legally constituted within a State to either provide administrative control or direction of, or perform a service function for public schools serving individuals ages 0 - 21 in a state, city, county, township, school district, or other political subdivision including a combination of school districts or counties recognized in a State as an administrative agency for its public schools. An LEA may provide, or employ professional who provide, services to children included in the Individuals with Disabilities Education Act (IDEA), such services may include, but are not limited to, such medical services as physical, occupational, and speech therapy.

Source: Portions of IDEA Regulations Part B (34 CFR Part 300.18, Assistance to States for the Education of Children with Disabilities) [1/1/2006: new]

Effective Date 4/1/2006

Nursing Care

251J00000X Nursing Care Agency

A Nursing Care Agency is an entity that provides skilled nursing care through the services of a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), by employees, contracted individuals, or via a registry, in a variety of settings. The agency may engage in providing private duty nursing and/or staffing services.

Source: National Uniform Claim Committee, 2008 [7/1/2008: modified definition]

Effective Date 4/1/2002

Program of All-Inclusive Care for the Elderly (PACE) Provider Organization

251T00000X PACE Provider Organization

A PACE provider organization is a not-for-profit private or public entity that is primarily engaged in providing PACE services(unique capitated managed care benefits for the frail elderly which include comprehensive medical and social services). The following characteristics also apply to a PACE organization. It must: have a governing board that includes community representation; be able to provide complete PACE services regardless of frequency or duration of services; have a physical site to provide adult day services; have a defined service area; have safeguards against conflict of interest; have demonstrated fiscal soundness and have a formal Participant Bill of Rights.

Source: Centers for Medicare and Medicaid, PACE Fact Sheet http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf [7/1/2006: new]

Effective Date 10/1/200

Public Health or Welfare

251K00000X Public Health or Welfare Agency

Definition to come...

Effective Date 4/1/2002

Agencies

Supports Brokerage

251X00000X Supports Brokerage Agency

A provider of service/function that assists participating individuals to make informed decisions about what will work best for them is consistent with their needs and reflects their individual circumstances. Serving as the agent of the individual, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services and may include assistance with recruiting, screening, hiring, and training in-home support providers. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem solving. The service/function provides sufficient information to assure that individuals understand the responsibilities involved with self-direction and assist in the development of an effective back-up and emergency plan. Plans may elect to fulfill the requirement of this service/function using a self-directed case manager or creating a distinct service. The Supports Brokerage documents the need for assistive services, planning for and documenting the use of excess funds and locating and maintaining services.

Source: CMS Independence Plus Waiver template. [7/1/2006: new]

Effective Date 10/1/200

Voluntary or Charitable

251V00000X Voluntary or Charitable Agency

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

261Q00000X Clinic/Center

A facility or distinct part of one used for the diagnosis and treatment of outpatients. "Clinic/Center" is irregularly defined, sometimes being limited to organizations serving specialized treatment requirements or distinct patient/client groups (e.g., radiology, poor, and public health).

Effective Date 4/1/2002

Specialization: Adolescent and Children Mental Health

261QM0855X Adolescent and Children Mental Health Clinic/Center

An entity, facility, or distinct part of a facility providing diagnostic, treatment, and prescriptive services related to mental and behavioral disorders in children and adolescents. Services may be provided to parents and family members of the patient in the form of conjoint, group, or individual therapy, and education and/or training.

[7/1/2003: new]

Effective Date 10/1/200

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Adult Day Care

261QA0600X Adult Day Care Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Adult Mental Health

261QM0850X Adult Mental Health Clinic/Center

An entity, facility, or distinct part of a facility providing diagnostic, treatment, and prescriptive services related to mental and behavioral disorders in adults.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Ambulatory Family Planning Facility

261QA0005X Ambulatory Family Planning Facility

An abortion/family planning facility where services are provided at a fixed specific location. An Ambulatory Family Planning Facility does not provide overnight accommodations. The following procedures may be performed at an Ambulatory Family Planning Facility: abortions, laproscopy, hysterectomies, tubule ligation and other related procedures. Abortion is considered voluntary termination of pregnancy.

Effective Date 4/1/2002

Specialization: Ambulatory Fertility Facility

261QA0006X Ambulatory Fertility Facility

A fertility facility, which may be licensed, registered, or certified in some states, that is not hospital-based, where services are provided at a fixed specific location. An Ambulatory Fertility Facility does not provide overnight accommodations. The following fertility procedures may be performed at an Ambulatory Fertility Facility: In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Embryo Transfer-Thaw (ET-T), Zygote Intrafallopian Transfer (ZIFT), Donor OOCYTE (DO)

Effective Date 4/1/2002

Specialization: Ambulatory Surgical

261QA1903X Ambulatory Surgical Clinic/Center

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Amputee

261QA0900X Amputee Clinic/Center

An entity, facility, or distinct part of a facility providing counseling, fitting, custom design, prescriptive, and training services related to congenital or postoperative absence of all or part of a limb or limbs.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Augmentative Communication

261QA3000X Augmentative Communication Clinic/Center

An entity, facility, or distinct part of a facility staffed by audiology and/or speech professionals with special training in the evaluation of a patient's potential for use of an augmentative communication device, determination of the most appropriate device, adjustment and maintenance of the device, and training the patient to use the device.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Birthing

261QB0400X Birthing Clinic/Center

A freestanding birth center is a health facility other than a hospital where childbirth is planned to occur away from the pregnant woman's residence, and that provides prenatal, labor and delivery, and postpartum care, as well as other ambulatory services for women and newborns.

Source: Summarized from Social Security Act [42 U.S.C. 1396d(1)(3)(B)] [1/1/2013: added definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2013

Specialization: Community Health

261QC1500X Community Health Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Corporate Health

261QC1800X Corporate Health Clinic/Center

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Critical Access Hospital

261QC0050X Critical Access Hospital Clinic/Center

An outpatient entity, facility, or distinct part of a facility within or affiliated with a Critical Access Hospital that provides access to primary care services for individuals in a small rural community and is Medicare certified.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Dental

261QD0000X Dental Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Developmental Disabilities

261QD1600X Developmental Disabilities Clinic/Center

An entity, facility, or distinct part of a facility providing comprehensive, multidiscipline diagnostic, treatment, therapy, training, and counseling services to children with congenital disorders that precipitate developmental delays and in many instances mental deficiencies (e.g., Cerebral Palsy, metabolic disorders, Sturge-Weber Syndrome, etc.).

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Emergency Care

261QE0002X Emergency Care Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Endoscopy

261QE0800X Endoscopy Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: End-Stage Renal Disease (ESRD) Treatment

261QE0700X End-Stage Renal Disease (ESRD) Treatment Clinic/Center

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Family Planning, Non-Surgical

261QF0050X Non-Surgical Family Planning Clinic/Center

An entity, facility, or distinct part of a facility, or mobile unit providing non-surgical, family planning/reproductive services including physical examination, laboratory services such as PAP or pregnancy tests; pregnancy, pregnancy prevention/contraceptive, and nutritional counseling, and contraceptives or prescriptions for contraceptives.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Federally Qualified Health Center (FQHC)

261QF0400X Federally Qualified Health Center (FQHC)

Definition to come...

Effective Date 4/1/2002

Specialization: Genetics

261QG0250X Genetics Clinic/Center

An entity, facility, or distinct part of a facility providing analysis of family history, genetic laboratory testing and analysis, diagnosis of genetic trait, prognosis and options. Laboratory studies may be outsourced.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Health Service

261QH0100X Health Service Clinic/Center

Definition to come...

[7/1/2006: modified title]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Hearing and Speech

261QH0700X Hearing and Speech Clinic/Center

An entity, facility, or distinct part of a facility providing diagnostic, treatment, prescriptive, and therapy services related to congenital and acquired conditions and diseases that affect hearing capacity and speech ability.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Infusion Therapy

261QI0500X Infusion Therapy Clinic/Center

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Lithotripsy

261QL0400X Lithotripsy Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Magnetic Resonance Imaging (MRI)

261QM1200X Magnetic Resonance Imaging (MRI) Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Medical Specialty

261QM2500X Medical Specialty Clinic/Center

An entity, facility, or distinct part of a facility providing diagnostic, treatment, and prescriptive services related to a specific area of medical specialization. Frequently used for Title V related Children's Specialty services or to meet specific public health needs (e.g., infectious diseases or breast and cervical cancer).

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Medically Fragile Infants and Children Day Care

261QM3000X Medically Fragile Infants and Children Day Care

An entity, facility, or distinct part of a facility specially equipped and staffed to provide care for medically fragile children with varied and complex care needs (e.g., enteral or parental feeding, ostomy care, respiratory/ventilator care, medications and therapies, etc.).

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Mental Health (Including Community Mental Health Center)

261QM0801X Mental Health Clinic/Center (Including Community Mental Health Center)

Definition to come...

Effective Date 4/1/2002

Specialization: Methadone

261QM2800X Methadone Clinic

An entity, facility, or distinct part of a facility providing diagnostic, and replacement maintenance treatment services related to individuals with drug addiction.

[7/1/2003: new]

Effective Date 10/1/200

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Migrant Health

261QM1000X Migrant Health Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Military Ambulatory Procedure Visits Operational (Transportable)

261QM1103X Military Ambulatory Procedure Visits Operational (Transportable) Clinic/Center

"Non-fixed" facilities or distinct parts of a "non-fixed" facility, providing outpatient surgical procedures requiring medically supervised recovery. Does not include items issued directly to a patient from an outpatient pharmacy or patient transport. Includes initial "take home" pharmaceuticals.

[1/1/2005: new]

Effective Date 4/1/2005

Specialization: Military and U.S. Coast Guard Ambulatory Procedure

261QM1101X Military and U.S. Coast Guard Ambulatory Procedure Clinic/Center

That part of a "fixed" (non-temporary, non-deployed) DoD or Coast Guard entity furnishing surgical procedures requiring medically supervised recovery. Similar to a civilian ambulatory surgical center. May be in shared resources with a DoD or Coast Guard Clinic or a DoD Hospital. Does not include items issued directly to a patient from an outpatient pharmacy or patient transport. Includes initial "take home" pharmaceuticals.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: title modified, definition added; 7/1/2006 title modified, definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Military Outpatient Operational (Transportable) Component

261QM1102X Military Outpatient Operational (Transportable) Component Clinic/Center

"Non-fixed" facilities or distinct parts of a "non-fixed" facility, providing outpatient medical and dental services, primarily intended for DoD active duty. The entity is funded with other than Defense Health Program funding. Non-DoD active duty may receive services from this entity. "Non-fixed" facilities are generally deployed DoD health care activities, not providing services on or in association with a DoD fort or base. "Non-fixed" facilities include outpatient services furnished onboard ships. "Non-fixed" facilities also include deployed clinics. Does not include items issued directly to a patient from an outpatient pharmacy or patient transport.

[1/1/2005: title modified, definition added]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Military/U.S. Coast Guard Outpatient

261QM1100X Military/U.S. Coast Guard Outpatient Clinic/Center

The Defense Health Program or U.S. Coast Guard funded "fixed" facilities or distinct parts of a facility, providing outpatient medical and dental services, primarily for Uniformed Services beneficiaries. A "fixed" facility is a non-temporary, non-deployed facility. It includes mobile specialty units such as Magnetic Resonance Imaging (MRI) units that may furnish services at the "fixed" facility. It includes, as examples, the institutional portion of outpatient encounters (except Ambulatory Procedure Visits), supplies issued (e.g., glasses, ostomy supplies, crutches), and radiology and laboratory studies. Does not include items issued directly to a patient from an outpatient pharmacy or patient transport.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: title modified, definition added; 7/1/2006 title modified, definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Multi-Specialty

261QM1300X Multi-Specialty Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Occupational Medicine

261QX0100X Occupational Medicine Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Oncology

261QX0200X Oncology Clinic/Center

An entity, facility, or distinct part of a facility providing diagnostic, treatment and prescriptive services related to cancerous conditions. Services include chemotherapy infusions and monitoring of implanted chemotherapeutic agents.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Oncology, Radiation

261QX0203X Radiation Oncology Clinic/Center

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Ophthalmologic Surgery

261QS0132X Ophthalmologic Surgery Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Oral and Maxillofacial Surgery

261QS0112X Oral and Maxillofacial Surgery Clinic/Center

The specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Pain

261QP3300X Pain Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Physical Therapy

261QP2000X Physical Therapy Clinic/Center

An entity, facility, or distinct part of a facility providing diagnostic and treatment services related to physical rehabilitation. Physical therapy is a dynamic profession with an established theoretical and scientific base and widespread clinical applications in the restoration, maintenance, and promotion of optimal physical function. Physical therapists and physical therapist assistants are licensed health care professionals who are experts in the movement system and help individuals maintain, restore, and improve movement, activity, and functioning, thereby enabling optimal performance and enhancing health, well-being, and quality of life. Their services prevent, minimize, or eliminate impairments of body functions and structures, activity limitations, and participation restrictions. Physical therapy is provided for individuals of all ages who have or may develop impairments, activity limitations, and participation restrictions related to (1) conditions of the musculoskeletal, neuromuscular, cardiovascular, pulmonary, and/or integumentary systems or (2) the negative effects attributable to unique personal and environmental factors as they relate to human performance.

Source: Guide to PT Practice 3.0 [1/1/2020: definition added] Additional resources: http://guidetoptpractice.apta.org/ ; American Physical Therapy Association, www.apta.org.

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Podiatric

261QP1100X Podiatric Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Primary Care

261QP2300X Primary Care Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Prison Health

261QP2400X Prison Health Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Public Health, Federal

261QP0904X Federal Public Health Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Public Health, State or Local

261QP0905X State or Local Public Health Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Radiology

261QR0200X Radiology Clinic/Center

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Radiology, Mammography

261QR0206X Mammography Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Radiology, Mobile

261QR0208X Mobile Radiology Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Radiology, Mobile Mammography

261QR0207X Mobile Mammography Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Recovery Care

261QR0800X Recovery Care Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Rehabilitation

261QR0400X Rehabilitation Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Rehabilitation, Cardiac Facilities

261QR0404X Cardiac Rehabilitation Clinic/Center

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)

261QR0401X Comprehensive Outpatient Rehabilitation Facility (CORF)

Definition to come...

Effective Date 4/1/2002

Specialization: Rehabilitation, Substance Use Disorder

261QR0405X Substance Use Disorder Rehabilitation Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Research

261QR1100X Research Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Rural Health

261QR1300X Rural Health Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Sleep Disorder Diagnostic

261QS1200X Sleep Disorder Diagnostic Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: Student Health

261QS1000X Student Health Clinic/Center

Definition to come...

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Urgent Care

261QU0200X Urgent Care Clinic/Center

Definition to come...

Effective Date 4/1/2002

Specialization: VA

261QV0200X VA Clinic/Center

Definition to come...

Effective Date 4/1/2002

Hospital Units

Epilepsy Unit

273100000X Epilepsy Hospital Unit

An Epilepsy Unit is a distinct unit of a hospital that provides services that may include observation, urgent care, diagnostic testing, treatment, and medication management for patients with seizure disorders.

Source: National Uniform Claim Committee [7/1/2007: new]

Effective Date 10/1/200

Medicare Defined Swing Bed Unit

275N00000X Medicare Defined Swing Bed Hospital Unit

A unit of a hospital that has a Medicare provider agreement and has been granted approval from HCFA to provide post-hospital extended care services and be reimbursed as a swing-bed unit.

Source: Code of Federal Regulations #42, Section 482.66.

Effective Date 4/1/2002

Hospital Units

Psychiatric Unit

273R00000X Psychiatric Hospital Unit

In general, a distinct unit of a hospital that provides acute or long-term care to emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment of psychiatric problems on the basis of physicians' orders and approved nursing care plans. Long-term care may include intensive supervision to the chronically mentally ill, mentally disordered or other mentally incompetent persons; (2) For Medicare, a distinct part of a general acute care hospital admitting only patients whose admission to the unit is required for active treatment, whose treatment is of an intensity that can be provided only in an inpatient hospital setting, and whose condition is described by a psychiatric principal diagnosis contained in the Third Edition of the American Psychiatric Association Diagnostic and Statistical Manual or in Chapter 5 (Mental Disorders) of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The unit must furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, occupational therapy, and recreational therapy. The unit must maintain medical records that permit determination of the degree and intensity of treatment provided to individuals who are furnished services in the unit; the unit must meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning.

Source: (1) AHA Annual Survey p. A10 1996 AHA Guide; (2) Code of Federal Regulations #42, Section 412.27.

Effective Date 4/1/2002

Rehabilitation Unit

273Y00000X Rehabilitation Hospital Unit

In general, a distinct unit of a general acute care hospital that provides care encompassing a comprehensive array of restoration services for the disabled and all support services necessary to help patients attain their maximum functional capacity. Source: AHA Annual Survey p. A10 1996 AHA Guide. For Medicare, a distinct part of a general acute care hospital providing inpatient rehabilitation services that meets the following requirements. Rehabilitation Units have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient program or assessment; ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy and occupational therapy, plus, as needed, speech therapy, social services or psychological services and orthotic and prosthetic services; have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment; have a director of rehabilitation who provides services to the unit and its inpatients for at least 20 hours a week, is a doctor of medicine or osteopathy, is licensed under State law to practice medicine or surgery, and has had, after completing a one-year hospital internship at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

Source: Code of Federal Regulations #42, Section 412.29.

Effective Date 4/1/2002

Hospital Units

Rehabilitation, Substance Use Disorder Unit

276400000X Substance Use Disorder Rehabilitation Hospital Unit

A distinct part of a hospital that provides medically monitored, interdisciplinary addiction-focused treatment to patients/clients who have psychoactive substance use disorders (commonly referred to as alcohol and drug abuse or substance abuse.)

Source: Department of Defense Regulation 6010.8-R, Chapter 6.

Effective Date 4/1/2002

Hospitals

Christian Science Sanitorium

287300000X Deactivated - Christian Science Sanitorium

Inactive, use 282J00000X

[7/1/2009: marked inactive]

Effective Date 4/1/2002 Deactivation Date 9/30/2009

Chronic Disease Hospital

281P00000X Chronic Disease Hospital

(1) A hospital including a physical plant and personnel that provides multidisciplinary diagnosis and treatment for diseases that have one or more of the following characteristics: is permanent; leaves residual disability; is caused by nonreversible pathological alteration; requires special training of the patient for rehabilitation; and/or may be expected to require a long period of supervision or care. In addition, patients require the safety, security, and shelter of these specialized inpatient or partial hospitalization settings. (2) A hospital that provides medical and skilled nursing services to patients with long-term illnesses who are not in an acute phase but who require an intensity of services not available in nursing homes.

Source: (1) Expanded from Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Specialization: Children

281PC2000X Children' s Chronic Disease Hospital

Definition to come...

Effective Date 4/1/2002

Hospitals

General Acute Care Hospital

282N00000X General Acute Care Hospital

An acute general hospital is an institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and non-surgical, to a wide population group. The hospital treats patients in an acute phase of illness or injury, characterized by a single episode or a fairly short duration, from which the patient returns to his or her normal or previous level of activity.

Effective Date 4/1/2002

Specialization: Children

282NC2000X Children's Hospital

Definition to come...

Effective Date 4/1/2002

Specialization: Critical Access

282NC0060X Critical Access Hospital

Definition to come.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Rural

282NR1301X Rural Acute Care Hospital

Definition to come...

Effective Date 4/1/2002

Specialization: Women

282NW0100X Women's Hospital

Definition to come...

Effective Date 4/1/2002

Long Term Care Hospital

282E00000X Long Term Care Hospital

Long-term care hospitals (LTCHs) furnish extended medical and rehabilitative care to individuals who are clinically complex and have multiple acute or chronic conditions.

Source: American Hospital Association [7/1/2006: new]

Effective Date 10/1/200

Hospitals

Military Hospital

286500000X Military Hospital

A health care facility operated by the Department of Defense.

Effective Date 4/1/2002

Specialization: Community Health

2865C1500X Deactivated - Military Hospital

[1/1/2005: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2005

Specialization: Military General Acute Care Hospital

2865M2000X Military General Acute Care Hospital

A Department of Defense (DoD) health care organization furnishing inpatient care 24 hours per day in "fixed" facilities, primarily for DoD beneficiaries. Entity is Defense Health Program (DHP) funded. A "fixed" facility is a non-temporary, non-deployed facility usually used for health care services. It includes mobile specialty units such as Magnetic Resonance Imaging (MRI) units that may furnish services at the "fixed" facility. It includes those services and institutional costs usually included in a Diagnosis Related Group as well as "pass-through" items.

[1/1/2005: title modified, definition added]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Specialization: Military General Acute Care Hospital. Operational (Transportable)

2865X1600X Operational (Transportable) Military General Acute Care Hospital

A Department of Defense (DoD) health care organization furnishing inpatient care 24 hours per day in "non-fixed" or deployed facilities. Entity is not Defense Health Program funded. Services are primarily intended for DoD active duty though some services may be furnished for non-DoD active duty. "Non-fixed" facilities are generally deployed DoD health care activities, not providing services on or in association with a DoD fort or base. "Non-fixed" facilities include hospital ships.

[1/1/2005: title modified, definition added]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Psychiatric Hospital

283Q00000X Psychiatric Hospital

An organization including a physical plant and personnel that provides multidisciplinary diagnostic and treatment mental health services to patients requiring the safety, security, and shelter of the inpatient or partial hospitalization settings.

Source: Expanded from Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Hospitals

Rehabilitation Hospital

283X00000X Rehabilitation Hospital

A hospital or facility that provides health-related, social and/or vocational services to disabled persons to help them attain their maximum functional capacity.

Source: Joint Commission on Accreditation of Healthcare Organizations, Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, Oakbrook Terrace, IL: 1994, p. 323

Effective Date 4/1/2002

Specialization: Children

283XC2000X Children's Rehabilitation Hospital

Definition to come...

Effective Date 4/1/2002

Religious Nonmedical Health Care Institution

282J00000X Religious Nonmedical Health Care Institution

Furnishes only nonmedical nursing items and services to patients who choose to rely solely upon a religious method of healing, and for whom the acceptance of medical services would be inconsistent with their religious beliefs. Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients. For example, caring for the physical needs such as assistance with activities of daily living; assistance in moving, positioning, and ambulation; nutritional needs; and comfort and support measures. Furnishes nonmedical items and services to inpatients on a 24-hour basis. Does not furnish, on the basis of religious beliefs, through its personnel or otherwise, medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients.

Source: Centers for Medicare & Medicaid Services, http://www.cms.hhs.gov/CertificationandComplianc/19_RNHCIs.asp#TopOfPage [7/1/2006: new]

Effective Date 10/1/200

Special Hospital

284300000X Special Hospital

A designation by the AHA of a hospital whose primary function of the institution is to provide diagnostic and treatment services for patients who have specified medical conditions, both surgical and nonsurgical.

Source: AHA Guide, Registration section, p. A5.

Effective Date 4/1/2002

Laboratories

Clinical Medical Laboratory

291U00000X Clinical Medical Laboratory

(1) A clinical laboratory is a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered clinical laboratories. (2) Any facility that examines materials from the human body for purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of, the health of human beings. Typical divisions of a clinical laboratory include hematology, cytology, bacteriology, histology, biochemistry, medical toxicology, and serology.

Source: (1) Code of Federal Regulations #42, Public Health, Section 493.2. (2)) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 186.

Effective Date 4/1/2002

Dental Laboratory

292200000X Dental Laboratory

A commercial laboratory specializing in the construction of dental appliances that conform to a dentist's specifications including the construction of dentures (complete or partial), orthodontic appliances, bridgework, crowns, and inlays.

Source: Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 1245.

Effective Date 4/1/2002

Military Clinical Medical Laboratory

291900000X Military Clinical Medical Laboratory

A Department of Defense (DoD) medical clinical reference laboratory not associated with a DoD Hospital or DoD Clinic. An example is the Armed Forces Institute of Pathology.

[1/1/2005: new]

Effective Date 4/1/2005

Laboratories

Physiological Laboratory

293D00000X Physiological Laboratory

A laboratory that operates independently of a hospital and physician's office to furnish physiological diagnostic services (e.g. EEG's , EKG's, scans, etc.). Facilities offering ONLY physiological services are not certified as independent laboratories. If an independent laboratory offers physiological services IN ADDITION to clinical laboratory services, they are surveyed only for compliance with the clinical laboratory regulations because there are no health and safety regulations for physiological services.

Source: Paraphrased from the Medicare Carrier Manual, Section 2070.5.

Effective Date 4/1/2002

Managed Care Organizations

Exclusive Provider Organization

302F00000X Exclusive Provider Organization

(1) An EPO is a form of PPO, in which patients must visit a caregiver that is specified on its panel of providers (is a participating provider). If a visit to an outside(not participating) provider is made the EPO offers very limited or no coverage for the medical service; (2) While similar to a PPO in that an EPO allows patients to go outside the network for care, if they do so in an EPO, they are required to pay the entire cost of care. An EPO differs from an HMO in that EPO physicians do not receive capitation but instead are reimbursed only for actual services provided; (3) An organization identical to a preferred provider organization except that persons enrolled in the plan are eligible to receive benefits only when they use the services of the contracting providers. No benefits are available when non-contracting providers are used, except in certain emergency situations.

Source: (1) Medical Interface: Managed Care A thru Z- Managed Care Terms published by Medicom International, Bronxville, New York Telephone (914) 337-5023, p. 15; (2) "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/October 1995, p. 58; (3) Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Managed Care Organizations

Health Maintenance Organization

302R00000X Health Maintenance Organization

(1) A form of health insurance in which its members prepay a premium for the HMO's health services which generally include inpatient and ambulatory care. For the patient, an HMO means reduced out-of-pocket costs (i.e. no deductible), no paperwork (i.e. insurance forms), and only a small copayment for each office visit to cover the paperwork handled by the HMO; (2) A organization of health care personnel and facilities that provides a comprehensive range of health services to an enrolled population for a fixed sum of money paid in advance for a specified period of time. These health services include a wide variety of medical treatments and consults, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services. The HMO may be organized as a group model, an individual practice association (IPA), a network model or a staff model.

Source: (1) Medical Interface: Managed Care A thru Z- Managed Care Terms published by Medicom International, Bronxville, New York Telephone (914) 337-5023, p. 20; (2) "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/October 1995, p. 58

Effective Date 4/1/2002

Point of Service

305S00000X Point of Service

This product may also be called an open-ended HMO and offers a transition product incorporating features of both HMOs and PPOs. Beneficiaries are enrolled in an HMO but have the option to go outside the networks for an additional cost.

Source: "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/October 1995, p. 62

Effective Date 4/1/2002

Preferred Provider Organization

305R00000X Preferred Provider Organization

A group of physicians and/or hospitals who contract with an employer to provide services to their employees. In a PPO, the patient may got to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Source: "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/ October 1995, p. 62

Effective Date 4/1/2002

Nursing & Custodial Care Facilities

Alzheimer Center (Dementia Center)

311500000X Alzheimer Center (Dementia Center)

A freestanding facility or special care unit of a long term care facility focusing on patient care of individuals diagnosed with dementia or Alzheimer's Disease or their related diseases. Six elements of the facility/unit set it apart from other (the rest of the) facilities(y): Admission of residents with dementia (including those with Alzheimer's disease); Staff who are specially selected, trained, and supervised; Activities that are specifically designed for the cognitively impaired; A marketing of a special care unit in brochures; A high level of family involvement; and A physical environment designed to keep residents safe and segregated from other populations.

Effective Date 4/1/2002

Assisted Living Facility

310400000X Assisted Living Facility

A facility providing supportive services to individuals who can function independently in most areas of activity, but need assistance and/or monitoring to assure safety and well being.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Assisted Living, Behavioral Disturbances

3104A0630X Assisted Living Facility (Behavioral Disturbances)

A facility providing supportive services to individuals who can function independently in most areas of activity, but exhibit abnormal behavioral responses and habits and therefore need special guidance, assistance and/or monitoring to assure safety and well being. This type of facility requires a staff with special training in dealing with and redirecting negative, violent or destructive behaviors.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Assisted Living, Mental Illness

3104A0625X Assisted Living Facility (Mental Illness)

A facility providing supportive services to individuals who can function independently in most areas of activity, but need special guidance, assistance and/or monitoring as the result of a psychiatric problem. This type of facility requires a staff with special training in mental health training and dealing with psychiatric emergencies.

[7/1/2003: new]

Effective Date 10/1/200

Christian Science Facility

317400000X Deactivated - Christian Science Facility

Inactive, use 282J00000X

[7/1/2009: marked inactive]

Effective Date 4/1/2002 Deactivation Date 9/30/2009

Nursing & Custodial Care Facilities

Custodial Care Facility

311Z00000X Custodial Care Facility

A facility providing care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel.

Source: Paraphrased from Section 3159 A3 of the Medicare Intermediary Manual.

Effective Date 4/1/2002

Specialization: Adult Care Home

311ZA0620X Adult Care Home Facility

A custodial care facility providing supportive and personal care services to disabled and/or elderly individuals who cannot function independently in most areas of activity and need assistance and monitoring to enable them to remain in a home like environment.

[7/1/2003: new]

Effective Date 10/1/200

Hospice, Inpatient

315D00000X Inpatient Hospice

A provider organization, or distinct part of the organization, which renders an interdisciplinary program providing palliative care, chiefly medical relief of pain and supporting services, which addresses the emotional, social, financial, and legal needs of terminally ill patients and their families where an institutional care environment is required for the patient.

Source: AHA Guide, American Hospital Association.

Effective Date 4/1/2002

Intermediate Care Facility, Mental Illness

310500000X Mental Illness Intermediate Care Facility

A nursing facility that provides an intermediate level of nursing care to individuals whose functional abilities are significantly compromise by mental illness.

[7/1/2003: new]

Effective Date 10/1/200

Nursing & Custodial Care Facilities

Intermediate Care Facility, Mentally Retarded

315P00000X Intellectual Disabilities Intermediate Care Facility

(1) A public institution for care of the mentally retarded or people with related conditions. (2) An institution giving active treatment to mentally retarded or developmentally disabled persons or persons with related conditions. The primary purpose of the institution is to provide health or rehabilitative services to such individuals.

Sources: (1) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL: 1994, p. 403 (2) Paraphrased from Code of Federal Regulations #42, Public Health, Section 440.150(c).

Effective Date 4/1/2002

Nursing Facility/Intermediate Care Facility

313M00000X Nursing Facility/Intermediate Care Facility

An institution (or a distinct part of an institution) which- (1) is primarily engaged in providing to residents- (A) skilled nursing care and related services for residents who require medical or nursing care, (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement with one or more hospitals.

Source: Paraphrased from Section 1919 (a) of the Social Security Act.

Effective Date 4/1/2002

Skilled Nursing Facility

314000000X Skilled Nursing Facility

(1) A skilled nursing facility is a facility or distinct part of an institution whose primary function is to provide medical, continuous nursing, and other health and social services to patients who are not in an acute phase of illness requiring services in a hospital, but who require primary restorative or skilled nursing services on an inpatient basis above the level of intermediate or custodial care in order to reach a degree of body functioning to permit self care in essential daily living. It meets any licensing or certification standards et forth by the jurisdiction where it is located. A skilled nursing facility may be a freestanding facility or part of a hospital that has been certified by Medicare to admit patients requiring subacute care and rehabilitation; (2) Provides non-acute medical and skilled nursing care services, therapy and social services under the supervision of a licensed registered nurse on a 24-hour basis.

Source: (1) "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/October 1995, p. 64; (2) AHA Guide, 1996 Annual Survey.

Effective Date 4/1/2002

Nursing & Custodial Care Facilities

Skilled Nursing Facility

Specialization: Nursing Care, Pediatric

3140N1450X Pediatric Skilled Nursing Facility

A nursing care facility designed and staffed for the provision of nursing care and appropriate educational and habilitative/rehabilitative services to children with multiple, complex or profound disabilities that can not be cared for in a less restrictive environment.

[7/1/2003: new]

Effective Date 10/1/200

Residential Treatment Facilities

Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities

320900000X Intellectual and/or Developmental Disabilities Community Based Residential Treat

A home-like residential facility providing habilitation, support and monitoring services to individuals diagnosed with intellectual and/or developmental disabilities.

[7/1/2003: new, 1/1/2021: modified title, modified definition]

Effective Date 10/1/200 Last Modified Date 1/1/2021

Community Based Residential Treatment Facility, Mental Illness

320800000X Mental Illness Community Based Residential Treatment Facility

A home-like residential facility providing psychiatric treatment and psycho/social rehabilitative services to individuals diagnosed with mental illness.

[7/1/2003: new]

Effective Date 10/1/200

Residential Treatment Facilities

Psychiatric Residential Treatment Facility

323P00000X Psychiatric Residential Treatment Facility

A residential treatment facility (RTF) is a facility or distinct part of a facility that provides to children and adolescents, a total, twenty-four hour, therapeutically planned group living and learning situation where distinct and individualized psychotherapeutic interventions can take place. Residential treatment is a specific level of care to be differentiated from acute, intermediate, and long-term hospital care, when the least restrictive environment is maintained to allow for normalization of the patient's surroundings. The RTF must be both physically and programmatically distinct if it is a part or subunit of a larger treatment program. An RTF is organized and professionally staffed to provide residential treatment of mental disorders to children and adolescents who have sufficient intellectual potential to respond to active treatment (that is, for whom it can reasonably be assumed that treatment of the mental disorder will result in an improved ability to function outside the RTF) for whom outpatient treatment, partial hospitalization or protected and structured environment is medically or psychologically necessary

Source: Champus Policy manual, Volume II, p. 6010.47M dated 9/12/94. Revision: Definition title revised 7/1/03

Effective Date 4/1/2002

Residential Treatment Facility, Emotionally Disturbed Children

322D00000X Emotionally Disturbed Childrens' Residential Treatment Facility

A residential facility that provides habilitation services and other care and treatment to children diagnosed with mental health illness, behavioral issues, and intellectual disabilities and are not able to live independently.

Source: U.S. Department of Defense Regulation 6010.8-R, Chapter 6. [1/1/2021: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2021

Residential Treatment Facility, Intellectual and/or Developmental Disabilities

320600000X Intellectual and/or Developmental Disabilities Residential Treatment Facility

A residential facility that provides habilitation services and other care and treatment to adults or children diagnosed with developmental and intellectual disabilities and are not able to live independently.

[7/1/2003: new. 1/1/2021: modified title and definition]

Effective Date 10/1/200 Last Modified Date 1/1/2021

Residential Treatment Facility, Physical Disabilities

320700000X Physical Disabilities Residential Treatment Facility

A residential facility that provides habilitation services and other care and treatment to adults or children diagnosed with physical disabilities and are not able to live independently.

[7/1/2003: new, 1/1/2021: modified definition]

Effective Date 10/1/200 Last Modified Date 1/1/2021

Residential Treatment Facilities

Substance Abuse Rehabilitation Facility

324500000X Substance Abuse Rehabilitation Facility

A facility or distinct part of a facility that provides a 24 hr therapeutically planned living and rehabilitative intervention environment for the treatment of individuals with disorders in the abuse of drugs, alcohol, and other substances.

[7/1/2003: modified title, modified definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2003

Specialization: Substance Abuse Treatment, Children

3245S0500X Children's Substance Abuse Rehabilitation Facility

A facility or distinct part of a facility that provides a 24 hr therapeutically planned living and rehabilitative intervention environment for the treatment of children with disorders in the use of drugs, alcohol, and other substances. Medical and supportive counseling services and education services are included.

[7/1/2003: new]

Effective Date 10/1/200

Respite Care Facility

Respite Care

385H00000X Respite Care

Definition to come.

Effective Date 4/1/2002

Specialization: Respite Care Camp

385HR2050X Respite Care Camp

A camping facility that provides specialized respite care to individuals requiring enhanced services to enable them to remain in the community, (e.g., those with developmental delays, intellectual disabilities, mental/behavioral disorders). The staff must have training in working with the target populations and dealing with emergency situations which might be related to or exacerbate the individual's condition.

[7/1/2003: new, 1/1/2021: modified definition]

Effective Date 10/1/200 Last Modified Date 1/1/2021

Specialization: Respite Care, Intellectual and/or Developmental Disabilities, Child

385HR2060X Child Intellectual and/or Developmental Disabilities Respite Care

A facility or distinct part of a facility that provides short term, residential care to children diagnosed with intellectual and/or developmental disabilities as respite for the regular caregivers.

[7/1/2003: new, 1/1/2021: modified definition]

Effective Date 10/1/200 Last Modified Date 1/1/2021

Respite Care Facility

Respite Care

Specialization: Respite Care, Mental Illness, Child

385HR2055X Child Mental Illness Respite Care

A facility or distinct part of a facility that provides short term, residential care to children, diagnosed with mental illness, as respite for the regular caregivers.

[7/1/2003: new]

Effective Date 10/1/200

Specialization: Respite Care, Physical Disabilities, Child

385HR2065X Child Physical Disabilities Respite Care

A facility or distinct part of a facility that providers short term, residential care to children, diagnosed with complex or profound disabilities as respite for the regular caregivers.

[7/1/2003: new]

Effective Date 10/1/200

Suppliers

Blood Bank

331L00000X Blood Bank

An institution (organization or distinct part thereof) that performs, or is responsible for the performance of, the collection, processing, storage and/or issuance of human blood and blood components, intended for transfusion. The institution may also collect, process, and/or distribute human tissue, including bone marrow and peripheral blood progenitor cells, intended for transplantation.

Source: American Association of Blood Banks, Standards for Blood Banks and Tranfusion, 17th ed.

Effective Date 4/1/2002

Department of Veterans Affairs (VA) Pharmacy

332100000X Department of Veterans Affairs (VA) Pharmacy

Department of Veterans Affairs (VA) Pharmacy means any place under VA jurisdiction where drugs are dispensed and Pharmaceutical Care is provided to enrolled Veterans, by licensed pharmacists. The Pharmacy is reviewed by JCAHO, utilizes the VA hospital's DEA number, and has a designated NCPDP number. VA facility pharmacies include Inpatient (Institutional), Outpatient, Consolidated Mail Outpatient Pharmacies (CMOPs), Research, Addiction Treatment Centers, Long Term Care and Community Based Outpatient Clinics Pharmacies. The VHA Pharmacy Benefits Management - Strategic Healthcare Group has oversight for professional and practice activities of VA Pharmacies. Each pharmacy is under the direct supervision of a U.S. or U.S. territory licensed pharmacist, and has staffing to meet its designated scope of service.

Source: Pharmacy Benefits Management - Strategic Healthcare Group, Veterans Health Administration, Department of Veterans Affairs [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Durable Medical Equipment & Medical Supplies

332B00000X Durable Medical Equipment & Medical Supplies

A supplier of medical equipment such as respirators, wheelchairs, home dialysis systems, or monitoring systems, that are prescribed by a physician for a patient's use in the home and that are usable for an extended period of time.

Effective Date 4/1/2002

Specialization: Customized Equipment

332BC3200X Customized Equipment (DME)

Definition to come...

Effective Date 4/1/2002

Specialization: Dialysis Equipment & Supplies

332BD1200X Dialysis Equipment & Supplies (DME)

Definition to come...

Effective Date 4/1/2002

Specialization: Nursing Facility Supplies

332BN1400X Nursing Facility Supplies (DME)

Definition to come...

Effective Date 4/1/2002

Specialization: Oxygen Equipment & Supplies

332BX2000X Oxygen Equipment & Supplies (DME)

Definition to come...

Effective Date 4/1/2002

Specialization: Parenteral & Enteral Nutrition

332BP3500X Parenteral & Enteral Nutrition Supplies (DME)

Definition to come...

Effective Date 4/1/2002

Suppliers

Emergency Response System Companies

333300000X Emergency Response System Companies

A supplier of a personal emergency response system (PERS), which is an electronic device that enables a patient to receive emergency assistance when needed. The PERS is one of two different methodologies of notification: (1) where the patient summons emergency assistance themselves directly through the device or (2) emergency assistance is summoned through secure activation by the caretaker/guardian, which sends the device location to emergency responders.

Source: National Uniform Claim Committee, 2010 [7/1/2007: new, 7/1/2010: modified]

Effective Date 10/1/200

Eye Bank

332G00000X Eye Bank

An eye bank procures and distributes eyes for transplant, education and research. To promote patient safety, donated eyes and donor medial histories are evaluated based on strict Eye Bank Association of America Medical Standards

Effective Date 4/1/2002

Eyewear Supplier

332H00000X Eyewear Supplier

An organization that provides spectacles, contact lenses, and other vision enhancement devices prescribed by an optometrist or ophthalmologist.

Effective Date 4/1/2002

Hearing Aid Equipment

332S00000X Hearing Aid Equipment

The manufacture and/or sale of electronic hearing aids, their component parts, and related products and services on a national basis.

Effective Date 4/1/2002

Home Delivered Meals

332U00000X Home Delivered Meals

Home-delivered meals are those services or activities designed to prepare and deliver one or more meals a day to an individual's residence in order to prevent institutionalization, malnutrition, and feelings of isolation. Component services or activities may include the cost of personnel, equipment, and food; assessment of nutritional and dietary needs; nutritional education and counseling; socialization services; and information and referral.

Source: Code of Federal Regulations #45, Part 96, Appendix A, Uniform Definition of Services.

Effective Date 4/1/2002

Suppliers

Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy

332800000X Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy

An Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy means a pharmacy operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, all of which are defined in Section 4 of the Indian Health Care Improvement Act, 25 U.S.C. 1603.

Source: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 [1/1/2006: new]

Effective Date 4/1/2006

Medical Foods Supplier

335G00000X Medical Foods Supplier

A supplier of special replacement foods for clients with errors of metabolism that prohibit them from eating a regular diet. Medical foods are lacking in the compounds which cause complications of the metabolic disorder, and are not generally available in grocery stores, health food stores, or pharmacies.

Source: The Children with Special Healthcare Needs (CSHCN) Services Program, a program of the Texas Department of State Health Services [10/1/2011: new]

Effective Date 10/1/201

Military/U.S. Coast Guard Pharmacy

332000000X Military/U.S. Coast Guard Pharmacy

A Department of Defense (DoD) or U.S. Coast Guard entity whose primary function is to store, prepare and dispense pharmaceuticals and other associated items to Uniformed Services beneficiaries. These pharmacies may be associated with a DoD or U.S. Coast Guard clinic, DoD Hospital or freestanding. Usually associated with outpatient services.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: new; 7/1/2006: modified title, modified definition]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Non-Pharmacy Dispensing Site

332900000X Non-Pharmacy Dispensing Site

A site other than a pharmacy that dispenses medicinal preparations under the supervision of a physician to patients for self-administration. (e.g. physician offices, ER, Urgent Care Centers, Rural Health Facilities, etc.)

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Organ Procurement Organization

335U00000X Organ Procurement Organization

A federally designated organization that works with hospital personnel in retrieval of organs for transplantation. The federal government designates an OPO's service area and the hospitals with which an OPO is to establish working relationships.

Effective Date 4/1/2002

Pharmacy

333600000X Pharmacy

A facility used by pharmacists for the compounding and dispensing of medicinal preparations and other associated professional and administrative services. A pharmacy is a facility whose primary function is to store, prepare and legally dispense prescription drugs under the professional supervision of a licensed pharmacist. It meets any licensing or certification standards set forth by the jurisdiction where it is located.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: added definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2006

Specialization: Clinic Pharmacy

3336C0002X Clinic Pharmacy

A pharmacy in a clinic, emergency room or hospital (outpatient) that dispenses medications to patients for self-administration under the supervision of a pharmacist.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Community/Retail Pharmacy

3336C0003X Community/Retail Pharmacy

A pharmacy where pharmacists store, prepare, and dispense medicinal preparations and/or prescriptions for a local patient population in accordance with federal and state law; counsel patients and caregivers (sometimes independent of the dispensing process); administer vaccinations; and provide other professional services associated with pharmaceutical care such as health screenings, consultative services with other health care providers, collaborative practice, disease state management, and education classes.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Pharmacy

Specialization: Compounding Pharmacy

3336C0004X Compounding Pharmacy

A pharmacy that specializes in the preparation of components into a drug preparation as the result of a Practitioner's Prescription Drug Order or initiative based on the Practitioner/Patient/Pharmacist relationship in the course of professional practice. A compounding pharmacy utilizes specialized equipment and specially designed facilities necessary to meet the legal and quality requirements of its scope of compounding practice.

Sources: NABP Model Practice Act, Appendix C - Good Compounding Practice, USP <795> and <797>, and Pharmacy Compounding Accreditation Board [7/1/2006: new]

Effective Date 10/1/200

Specialization: Home Infusion Therapy Pharmacy

3336H0001X Home Infusion Therapy Pharmacy

Pharmacy-based, decentralized patient care organization with expertise in USP 797-compliant sterile drug compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional formulae administered through catheters and/or needles in home and alternate sites. Extensive professional pharmacy services, care coordination, infusion nursing services, supplies and equipment are provided to optimize efficacy and compliance.

Source: National Home Infusion Association [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Institutional Pharmacy

3336I0012X Institutional Pharmacy

A pharmacy in a hospital (inpatient) or institution used by pharmacists for the compounding and delivery of medicinal preparations to be administered to the patient by nursing or other authorized personnel. Institutional Pharmacies also counsel patients and caregivers; administer vaccinations; and provide other professional services associated with pharmaceutical care such as health screenings, consultative services with other health care providers, collaborative practice, disease state management, and education classes.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Long Term Care Pharmacy

3336L0003X Long Term Care Pharmacy

A pharmacy that dispenses medicinal preparations delivered to patients residing within an intermediate or skilled nursing facility, including intermediate care facilities for mentally retarded, hospice, assisted living facilities, group homes, and other forms of congregate living arrangements.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Pharmacy

Specialization: Mail Order Pharmacy

3336M0002X Mail Order Pharmacy

A pharmacy where pharmacists compound or dispense prescriptions or other medications in accordance with federal and state law, using common carriers to deliver the medications to patient or their caregivers. Mail order pharmacies counsel patients and caregivers (sometimes independent of the dispensing process) through telephone or email contact and provide other professional services associated with pharmaceutical care appropriate to the setting. Mail order pharmacies are licensed as a Mail Order Pharmacy in the state where they are located and may also be licensed or registered as nonresident pharmacies in other states.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Managed Care Organization Pharmacy

3336M0003X Managed Care Organization Pharmacy

A pharmacy owned by a managed care organization (MCO) used by pharmacists for the compounding and dispensing of medicinal preparations to that MCO's covered members only.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Nuclear Pharmacy

3336N0007X Nuclear Pharmacy

A pharmacy dedicated to the compounding and dispensing of radioactive materials for use in nuclear imaging and nuclear medical procedures.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Specialty Pharmacy

3336S0011X Specialty Pharmacy

A pharmacy that dispenses generally low volume and high cost medicinal preparations to patients who are undergoing intensive therapies for illnesses that are generally chronic, complex and potentially life threatening. Often these therapies require specialized delivery and administration.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Portable X-ray and/or Other Portable Diagnostic Imaging Supplier

335V00000X Portable X-ray and/or Other Portable Diagnostic Imaging Supplier

A supplier that provides one or more of the following portable services, including but not limited to, x-ray, electrocardiogram (EKG), long-term EKG (Holter Monitor), bone densitometry, sonography, and other imaging services in accordance with all state and federal requirements, under the general supervision of a qualified physician. All necessary resources are transported to the patient's location where the services are performed.

Source: National Uniform Claim Committee, 2015 [1/1/2016: title and definition modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2016

Prosthetic/Orthotic Supplier

335E00000X Prosthetic/Orthotic Supplier

An organization that provides prosthetic and orthotic care which may include, but is not limited to, patient evaluation, prosthesis or orthosis design, fabrication, fitting and modification to treat limb loss for purposes of restoring physiological function and/or cosmesis or to treat a neuromusculoskeletal disorder or acquired condition.

Source: American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. [7/1/2010: modified, 7/1/2013: modified] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 4/1/2002 Last Modified Date 7/1/2013

Transportation Services

Air Carrier

344800000X Air Carrier

An air company that the Federal Aviation Administration, the certificate-holding district office (CHDO), regional Flight Standards Division (RFSD) offices, and AFS-900 has verified that the company is capable of operating safely and that it complies with the regulations and standards prescribed by the Administrator.

Source: Federal Aviation Administration [1/1/2010: new] Additional Resources: www.faa.gov/about/initiatives/atos/air_carrier/intro_to_part121_cert/

Effective Date 4/1/2010

Transportation Services

Ambulance

341600000X Ambulance

An emergency vehicle used for transporting patients to a health care facility after injury or illness. Types of ambulances used in the United States include ground (surface) ambulance, rotor-wing (helicopter), and fixed-wing aircraft (airplane).

Source: Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 37.

Effective Date 4/1/2002

Specialization: Air Transport

3416A0800X Air Ambulance

Definition to come...

[1/1/2005: title modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Specialization: Land Transport

3416L0300X Land Ambulance

Definition to come...

[1/1/2005: title modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Specialization: Water Transport

3416S0300X Water Ambulance

Definition to come...

[1/1/2005: title modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Bus

347B00000X Bus

A public or private organization or business licensed to provide bus services.

Effective Date 4/1/2002

Transportation Services

Military/U.S. Coast Guard Transport

341800000X Military/U.S. Coast Guard Transport,

Definition to come...

[1/1/2005: new; 7/1/2006 title modified]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Specialization: Military or U.S. Coast Guard Ambulance, Air Transport

3418M1120X Military or U.S. Coast Guard Air Transport Ambulance

Vehicle and staff for patient emergency or non-emergency air transport.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: new; 7/1/2006 modified title, added source]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Specialization: Military or U.S. Coast Guard Ambulance, Ground Transport

3418M1110X Military or U.S. Coast Guard Ground Transport Ambulance

Vehicle and staff for patient emergency or non-emergency ground transport. Includes traditional ambulances as well as ambulance buses.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: new; 7/1/2006 modified title, added source]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Specialization: Military or U.S. Coast Guard Ambulance, Water Transport

3418M1130X Military or U.S. Coast Guard Water Transport Ambulance

Vehicle and staff for patient emergency or non-emergency sea/water transport

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: new; 7/1/2006 modified title, added source]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Non-emergency Medical Transport (VAN)

343900000X Non-emergency Medical Transport (VAN)

A land vehicle with a capacity to meet special height, clearance, access, and seating, for the conveyance of persons in non-emergency situations. The vehicle may or may not be required to meet local county or state regulations.

Effective Date 4/1/2002

Transportation Services

Private Vehicle

347C00000X Private Vehicle

An individual paid to provide non-emergency transportation using their privately owned/leased vehicle.

Effective Date 4/1/2002

Secured Medical Transport (VAN)

343800000X Secured Medical Transport (VAN)

A public or privately owned transportation service with vehicles, specially equipped to provide enhanced safety, security and passenger restraint, and staffed by one or more individuals trained to work with patients in crisis situations resulting from mental or emotional illness and/or substance abuse.

Effective Date 4/1/2002

Taxi

344600000X Taxi

A land commercial vehicle used for the transporting of persons in non-emergency situations. The vehicle meets local, county or state regulations set forth by the jurisdictions where it is located.

Effective Date 4/1/2002

Train

347D00000X Train

An organization or business licensed to provide passenger train service, including light rail, subway, and traditional services.

Effective Date 4/1/2002

Transportation Broker

347E00000X Transportation Broker

An organization that provides transportation for individuals who need access to medical care or services and have no other means of transportation. Transportation includes, but is not limited to, wheelchair van, taxi, stretcher car, bus passes and tickets, and secured transportation.

Source: Section 6083 of the Deficit Reduction Act of 2005 [1/1/2021: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2021

Transportation Services

Transportation Network Company

342000000X Transportation Network Company

A ride-sharing company that provides prearranged or contracted non-emergency medical transportation services to patients through mobile or online technology.

Source: National Uniform Claim Committee, www.nucc.org [1/1/2021: new]

Effective Date 4/1/2021

Policy:	EE.1103Δ
Title:	**Provider ~~Education and~~Network Training**
Department:	Network Operations
Section:	Provider Relations
Interim CEO Approval:	*/s/*
Effective Date:	03/01/2001
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 2022-2023 BOD Review Only

I. PURPOSE

This policy outlines the ~~initial~~education and ~~ongoing~~ training ~~and education~~ requirements for Newly Contracted Provider and annual training provided by CalOptima and its Health Networks to medical, behavioral health, and Long-Term Services and Support (LTSS) Providers~~,~~ (hereinafter referred to as "Network Providers") and Subcontractors who serve CalOptima's Members participating in ~~CalOptima's~~CalOptima Medi-Cal, OneCare Connect, OneCare and Program of All-Inclusive Care for the Elderly (PACE) programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima shall train all CalOptima Direct-Administrative and CalOptima Community Network participating Network Providers ~~generally:~~ and Subcontractors for Medi-Cal, OneCare, OneCare Connect and PACE programs in accordance with this Policy.

B. CalOptima shall ensure training of staff that interact with Members in accordance with CalOptima Policy AA.1250Δ: Disability Awareness and Sensitivity, and Cultural Competency Staff Training.

C. A Health Network shall ensure training of Health Network staff that interact with Members in accordance with this Policy.

D. Network Providers: CalOptima or a Health Network shall provide ~~initial~~Newly Contracted Provider and ~~recurring~~annual training to ~~all contracted~~ Network Providers who serve CalOptima's Members participating in CalOptima's health care programs~~. Additionally,~~ , in accordance with applicable DHCS and CMS requirements and Section III.A. of this Policy.

1. CalOptima ~~will provide~~ shall require disability and cultural competency training for its Network Providers in accordance with Section III.B. of this Policy.

2. CalOptima and Health Networks shall develop and implement a process to provide information to Network Providers and to train providers on a continuing basis regarding clinical protocols and evidenced-based practice guidelines and DHCS developed cultural awareness and sensitivity instructions for Seniors and Persons with Disabilities (SPD).

   a. This process shall include an educational program for Network Providers regarding health needs specific to SPD Members that utilizes a variety of educational strategies, including

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but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

b. Individuals covered by this requirement include, but are not limited to, CalOptima and Health Network staff~~appropriate~~ that interact with Members, as applicable, contracted CalOptima and Health Network Primary Care Physicians (PCPs), specialists who serve a high-volume of SPD Members, and speech, occupational, and physical therapists, in accordance with Welfare and Institutions Code section 14182(b)(5).

E. Designated County Agencies: CalOptima shall provide training to staff of designated county agencies with which CalOptima partners that interact with Members, as applicable, and in accordance with Section III.B.1. of this Policy.

F. For out-of-network Providers who will not receive Network Provider training, CalOptima or a Health Network shall develop and implement a process to provide the out-of-network Provider with clinical protocols, evidence-based practice guidelines, and the Special Needs Plan (SNP) Model of Care. CalOptima or a Health Network shall arrange to provide these protocols and guidelines at the time that CalOptima or a Health Network enters into an agreement with an out-of-network Provider.

1. CalOptima shall require disability and cultural competency training for its Network Providers in accordance with Section III.C. of this Policy.

G. PACE Providers shall complete training prior to commencement of services to PACE Participants.

H. CalOptima shall review Health Network reports to ensure compliance with Newly Contracted Provider and annual training.

I. CalOptima and each Health Network shall make a Provider Manual accessible to all Network Providers and Subcontractors.

J. Training attestations shall be required as provided in Sections III.E-F. of this Policy.

K. For purposes of this policy, the Newly Contracted Provider training and annual training are referred to as separate and distinct trainings due to the timeframe requirements for each training. The content included in Newly Contracted Provider training and annual training is the same.

III. PROCEDURE

A. Newly Contracted Provider Training

1. Newly Contracted Provider and Annual Training for Network Providers shall be provided as follows:

a. CalOptima or Health Network shall initiate training for all Network Providers and Subcontractors no later than ten (10) working days and shall complete the training within thirty (30) calendar days of placing them on Active Status.

b. Training materials shall include, but are not limited to the following:

i. Training agenda;

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ii. Training presentation;

iii. Training handouts;

iv. Applicable CalOptima or Health Network resource and contact information;

v. Attendance roster;

vi. Training attestation; and

vii. Training evaluation form.

2. Health Networks shall attest that appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness and sensitivity instructions for SPDs in accordance with Welfare and Institutions Code section 14182(b)(5).

3. CalOptima shall provide training on key elements of operating a successful program for administering Managed Long-Term Services and Supports (MLTSS).

4. Upon completion of the training, the Network Provider shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima or the Health Network.

5. If CalOptima or a Health Network is unable to complete the training within the thirty (30) calendar day requirement, CalOptima or Health Network shall send materials to the Network Provider's office, and document reasons and actions taken due to non-completion of the training.

6. CalOptima and its Health Networks shall track completion of the Network Provider's training, including the date of completion of the training.

7. A Health Network shall submit a completed Health Network Newly Contracted Provider Office Training Report to CalOptima on a quarterly basis, on or before the twenty-fifth (25th) day of the month, following the end of the quarter. If the twenty-fifth (25th) day falls on a non-business day, the Health Network shall submit the report no later than the next business day.

8. CalOptima or a Health Network shall retain training records for a period of at least ten (10) years.~~.~~

~~A.~~B. Network Provider and Subcontractor Annual Training

1. CalOptima or Health Networks shall provide annual training for Network Providers and Subcontractors:

a. Annual training required one time per year;

b. When conducting Provider forums, meetings, outreach visits;

c. When determined necessary through notification to Providers of newly contracted product lines or updates to existing product services, performance data, such as complaint and grievance data, Member and Provider satisfaction and accessibility surveys, and practices serving a high volume of targeted populations;

~~a.~~d. Upon request from Providers; and

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~~b.~~e. When CalOptima or one of its regulators determines that a Provider has discriminated against a CalOptima Member.

C. Newly Contracted Provider Training and Annual Training Material

1. As specified in Attachment B, Newly Contracted Provider training and annual training will include, at a minimum:

   a. CalOptima programs and initiatives, including but not limited to, the California Advancing and Innovating Medi-Cal (CalAIM) and the Whole-Child Model (WCM) program ~~and Health Homes Program;~~;

   b. CalOptima/Health Network operations;

   c. Provider communications;

   d. Member rights and responsibilities;

   e. CalOptima policies and procedures;

   f. Individual Health Education Behavioral Assessment (IHEBA) contract requirements;

   g. Member benefits;

   h. Claims submission and payment;

   i. Coordination of benefits;

   j. Conflict resolution;

   k. Critical ~~Incident~~incident reporting;

   l. Member Grievance and Appeals process;

   m. Member billing restrictions;

   ~~m.~~n. Utilization Management Appeals and Provider dispute resolution process; ~~and~~

   ~~n.~~o. Prior authorization process~~.~~;

   p. ~~Cultural~~Medical management and authorization requirements;

   ~~o.~~q. Customer service, cultural and linguistic requirements and cultural competency training;

   r. Community Based Adult Services;

   s. Behavioral Health;

   t. Medical management delegation and payment responsibility;

   u. Medi-Cal and Medicare Member eligibility verification and disenrollment process;

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~~p.~~v. Seniors and Persons with Disabilities (SPD) trainings;
~~q.~~w. Fraud, Waste, and Abuse and compliance training;

~~r.~~x. OneCare Connect Program Overview;

~~s.~~y. Model of Care;

~~t.~~z. Access standards; ~~and~~

~~u.~~aa. ~~Subcontracted~~Subcontract Network Certification requirements~~.~~;

bb. ~~Medical, Behavioral Health~~Reporting requirements;

cc. Long-Term Support Services (LTSS);

dd. Authorizations, claims and ~~LTSS Providers: CalOptima shall require disability~~Member eligibility verification process for hospitals, skilled nursing facilities and ~~cultural competency~~ancillary providers;

~~v.~~ee. Disability training ~~for its medical, behavioral health, and LTSS Providers~~information, including ~~information about~~, but not limited to, the following~~:~~:

i. ~~Various types of~~ Chronic ~~Conditions~~conditions prevalent within the ~~target~~ population;

ii. Awareness of personal prejudices;

iii. Legal obligations to comply with the Americans ~~with Disabilities~~Disability Act (ADA) ~~requirements~~ and Section 504 of the Rehabilitation Act;

iv. Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs;

v. Types of barriers encountered by the target population;

vi. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles, and the recovery model;

~~1. Use of clinical protocols, evidence-based practices, and specific levels of quality outcomes;~~

~~2. Use of culturally competent practices and access to services in a culturally competent manner for all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code section 422.56;~~

vii. Working with Members with mental health diagnoses, including crisis prevention and treatment;

viii. Working with Members with substance use conditions, including diagnosis and treatment; and

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ix. HIV stigma and non-discrimination requirements.;

ff. Quality improvement for health services programs;

~~a. CalOptima shall develop and make available training to staff and Providers, as applicable, who interact with Medi-Cal SPD Members, on standards for competency, cultural awareness, and sensitivity.~~

~~1. Individuals covered by this requirement include, but are not limited to, CalOptima and Health Network staff, contracted CalOptima and Health Network PCPs, Practitioners, high-volume specialists, and speech, occupational, and physical therapists, in accordance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 11-010 and Welfare and Institutions Code, section 14182(b)(5).~~

~~D. CalOptima or Health Networks shall also provide and disseminate additional ongoing training for contracted Providers:~~

~~a. Refresher training on an annual basis:~~

~~a. Cultural competency training;~~

~~b. SPD trainings;~~

~~c. Fraud, Waste, and Abuse and compliance training;~~

~~d. OneCare Connect Program Overview;~~

~~e. Model of Care;~~

~~f. Access standards and~~

~~g. Subcontracted Network Certification requirements.~~

~~c.~~a. ~~When conducting Provider forums, meetings, outreach visits;~~

~~2. When determined necessary;~~

~~d.~~a. ~~Upon request from Providers; and~~

~~3. When CalOptima or one of its regulators determines that a Provider has discriminated against a CalOptima Member.~~

~~E. CalOptima shall educate all CalOptima Direct and CalOptima Community Network contracted **Providers**. All **Health Networks** shall educate their contracted **Providers**, in accordance with DHCS and CMS requirements.~~

gg. ~~CalOptima or a Health Network shall retain training records for a period of at least ten (10) years.~~Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+) cultural competency training;

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~~F.~~ Use of culturally competent practices and access to services in a culturally competent manner for all Members regardless of ~~-~~

~~III. PROCEDURE~~

~~B. Initial and Recurring Training for Contracted Medical, Behavioral Health, and LTSS Providers~~

hh. ~~CalOptima or a Health Network shall conduct training for a newly contracted medical, behavioral health,~~ sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and

i. Use of clinical protocols, evidence-based practices, and specific levels of quality outcomes.

D. Provider Manual Requirements

~~1.~~ CalOptima or ~~LTSS Provider within ten (10) business days from the Provider's placement on Active Status.~~

1. ~~CalOptima or~~ a Health Network~~, as necessary,~~ shall make a Provider Manual accessible to all ~~contracted medical, behavioral health, and LTSS~~Network Providers and Subcontractors. The Provider Manual shall include, at a minimum, the following information:

   a. Updates and revisions;

   b. Overview and Model of Care;

   c. CalOptima or Health Network contact information;

   d. Member benefits covered by CalOptima;

   e. Eligibility determination and verification process;

   f. Quality improvement for health services programs;

   ~~w.a. Quality improvement for health services programs;~~

   ~~f.~~g. Member rights and responsibilities;

   ~~g.~~h. Provider billing and reporting;

   ~~h.~~i. The Member problem resolution ~~processes;~~process;

   ~~i.~~j. The authorization process;

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~~j.~~k. Provider cultural and linguistic requirements;

~~k.~~l. Regulatory and contractual requirements; and

~~l.~~m. Other activities and services needed to assist Members in optimizing their health status, including assistance with self-management skills or techniques, health education, and other modalities to improve health status.

E. ~~CalOptima or a~~ Health Network Training Materials

1. By or before January 15 of each year, Health Networks shall attest that all Health Network Providers participating with CalOptima and Health Networks, have completed, attested, and retained such records of Newly Contracted Provider and Annual Training located on CalOptima's website www.caloptima.org. Training materials to include the following:

   a. OneCare Connect Program Overview;

   b. Cultural Competency Training;

   c. Disability Awareness Training;

   d. OneCare Model of Care; and

   e. Fraud, Waste~~shall complete~~ and Abuse Training.

F. Training Attestations Requirements

1. Training attestations are required for:

   a. Health Networks, Network Providers, Subcontractors, and all personnel that completed CalOptima's training.

      i. All staff who interact or potentially interact with Medi-Cal, OneCare, OneCare Connect Members, and SPD beneficiaries;

      ii. All staff who are responsible for policies and procedures affecting Medi-Cal, OneCare, OneCare Connect members and Seniors and Persons with Disabilities beneficiaries; and

      iii. Any other staff deemed appropriate by CalOptima, CMS or DHCS.

   b. A Health Network, Network Provider or Subcontractor shall provide the following information on the training attestation:

      i. Organization name;

      ii. Date of completed training;

      iii. Name of individual attesting; and

      iv. Signature of individual attesting.

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c. CalOptima Provider Relations Department shall validate that the following requirements are met:

i. Training for all Network Providers is initiated no later than ten (10) working days after CalOptima places a newly contracted Network Provider on Active Status and completed within thirty (30) calendar days of placing on Active Status;

~~i.~~ii. A signed attestation is obtained from the ~~Provider's placement on Active Status.~~Network Provider; and

~~2. Upon completion of the training, the Provider shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima or the Health Network.~~

iii. ~~If~~Health Networks shall submit Newly Contracted Provider and annual training reports pursuant to CalOptima Policy HH.2003Δ: Health Network and Delegated Entity Reporting. The Newly Contracted Provider and annual training reports on the reporting grid reflect the reporting submission requirements.

G. Health Network and Delegated Entity Reporting

1. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima as required by CalOptima or ~~a Health Network is unable to complete the training within the thirty (30) calendar day requirement, CalOptima~~as specified in its contract or ~~Health Network~~ CalOptima's policies and procedures in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

2. CalOptima Provider Relations Department shall ~~send materials~~be accountable for:

a. Identifying required reports;

b. Ensuring that all reports list all applicable regulatory, contractual, and policy citations and include all required data elements;

c. Creating templates and all applicable reporting formats, instructions, and technical guidelines;

d. Monitoring submission and timeliness of reports;

e. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

f. Notifying Health Network Relations of unsuccessful follow-up attempts; and

g. Escalating issues of continued noncompliance to the ~~Provider's office, and document reasons and~~ Office of Compliance.

~~1.~~3. The Office of Compliance shall be responsible for taking appropriate corrective actions ~~taken due~~in response to ~~non-completion of the education~~reported issues of noncompliance, in accordance with CalOptima's Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

4. The Office of Compliance shall be responsible for annual audit of CalOptima and ~~its~~ Health Networks ~~shall track completion of the Provider's education, including the date of~~

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~~completion~~provider training in accordance with CalOptima Policy GG.1619: Delegation Oversight.

~~C.~~H. Verification of ~~the education.~~ Network Provider Training

~~1. A Health Network shall submit a completed Health Network Newly Contracted Provider Office Training Report to CalOptima on a quarterly basis, on or before the twenty-fifth (25th) day of the month, following the end of the quarter. If the twenty-fifth (25th) day falls on a non-business day, the Health Network shall submit the report no later than the next business day.~~

1. CalOptima and Health Networks shall ~~provide written confirmation~~verify that ~~appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness~~Network Providers attest to Newly Contracted Provider and ~~sensitivity instructions for SPDs~~annual training.

2. Verification

   a. On a quarterly basis, CalOptima shall obtain Newly Contracted Provider and annual training attestations from Health Networks and CalOptima Community Network (CCN).

   b. Health Networks and CCN shall document the outcome of each attempt to obtain Newly Contracted Provider and Annual Training attestations.

   c. CalOptima shall monitor training attestation compliance annually in accordance with this Policy.

IV. ATTACHMENT(S)

A. ~~Health Network~~ Newly Contracted Provider and ~~Practitioner Office~~Annual Training ~~Form~~
B. Provider Network Training ~~Descriptions~~

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
~~D. Department of Health Care Services (DHCS) All Plan Letter 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities~~
D. CalOptima Policy AA.1250Δ: Disability Awareness and Sensitivity, and Cultural Competency Staff Training.
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. Medicare Managed Care Manual, Chapter 5, Section 20.2.2, MOC 3, Element C, Factors 1 and 2
~~E.~~J. Title 42, Code of Federal Regulations (CFR), §§422.101(f)(2)(ii), 438.3(u), 438.206(c)(2), 438.236(c), and 438.414
~~F.~~K. Welfare and Institutions (W&I) Code, §14182 (b~~) ()~~(5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response

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04/29/2010	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2001	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	07/01/2007	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	01/01/2009	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	11/01/2012	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	03/01/2015	EE.1103Δ	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2015	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2016	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	EE.1103Δ	Provider Network Training	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with CalOptima, or a Health Network ~~or physician group~~. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within that group.
Appeal	Medi-Cal: A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a Covered Service. Includes a request for a fair hearing in accordance with California Code or Regulations (CCR) Titled 22, Section 51014 and Welfare and Institutions Code section 10950. OneCare and OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review. PACE: A Participant's action taken with respect to the CalOptima PACE's non-coverage of, or nonpayment for, a service, including denials, reductions or termination of services. An Appeal may be filed verbally, either in-person or by telephone, or in writing. The Appeal process may take one (1) of two (2) forms: 1. Standard Appeal: A standard review process for response to and resolution of an Appeal as expeditiously as the Participant's health requires, but no later than thirty (30) days after the CalOptima PACE receives an Appeal. 2. Expedited Appeal: When a Participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute. CalOptima PACE shall respond to the Appeal as expeditiously as the Participant's health condition requires, but no later than seventy-two (72) hours after it receives the Appeal. The seventy-two (72)-hour timeframe may be extended by up to fourteen (14) calendar days for either of the following reasons: a. The Participant requests the extension; or ~~a.~~b. The PACE organization justifies to the State administering agency the need for additional information, and how the delay is in the interest of the Participant.
California Advancing and Innovating Medi-Cal (CalAIM)	A multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.

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Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, C alifornia Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Direct - Administrative	The managed Fee-For-Service health care program operated by CalOptima that provides services to Members who meet certain eligibility criteria as described in CalOptima Policy DD.2006 Enrollment in/Eligibility with CalOptima Direct.
Chronic Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Centers for Medicare & Medicaid Services (CMS)	A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Community Based Adult Services (CBAS)	Offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.
Critical Incident	Critical incident refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Department of Healthcare Services (DHCS)	A department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs.
Delegated Entity	For purposes of this policy, a Delegated Entity is contracted with CalOptima to provide covered services to eligible CalOptima Members including but not limited to medical, dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Members.
Grievance	Medi-Cal: An expression of dissatisfaction about any matter other than an adverse benefit determination. OneCare and OneCare Connect: Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action. PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care. A Grievance may include, but is not limited to: 1. The quality of services a Participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility); 2. Waiting times on the telephone, in the waiting room or exam room; 3. Behavior of any of the care providers or PACE employees; 4. Adequacy of center facilities; 5. Quality of the food provided; 6. Transportation services; and 7. A violation of a Participant's rights.

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Term	Definition
~~Health Homes Program~~	~~All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.~~
Health Network	For purposes of this policy, 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 to provide Covered Services to Members assigned to that Health Network.
Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+)	For purposes of this policy, LGBTQIA+ is an acronym for Members that identify as lesbian, gay, bisexual, transgender and queer and/or questioning, asexual.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Network Provider	For purposes of this policy, a Provider that is contracted with CalOptima or a Health Network contracted with CalOptima for the delivery of Medi-Cal covered services.
Newly Contracted Provider	For purposes of this policy, a Provider that is newly contracted ten (10) days after active status with CalOptima or a Health Network contracted with CalOptima for the delivery of Medi-Cal covered services.
Participant	An individual enrolled in the CalOptima PACE program.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist Physician~~ Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a ~~non~~Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a ~~specialist~~specialty care provider or clinic ~~in accordance with W & I Code 14182(b)(11).~~.

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Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Subcontractor	A Provider of health care services who agrees to furnish covered services to Members with a written agreement with CalOptima.
Threshold Language	Medi-Cal/OneCare Connect: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Whole ~~-~~Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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For 20220203 BOD Review Only

Policy:	EE.1103Δ
Title:	**Provider Network Training**
Department:	Network Operations
Section:	Provider Relations
Interim CEO Approval:	*/s/*
Effective Date:	03/01/2001
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20220203 BOD Review Only

I. PURPOSE

This policy outlines the education and training requirements for Newly Contracted Provider and annual training provided by CalOptima and its Health Networks to medical, behavioral health, and Long-Term Services and Support (LTSS) Providers (hereinafter referred to as "Network Providers") and Subcontractors who serve CalOptima's Members participating in CalOptima Medi-Cal, OneCare Connect, OneCare and Program of All-Inclusive Care for the Elderly (PACE) programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima shall train all CalOptima Direct-Administrative and CalOptima Community Network participating Network Providers and Subcontractors for Medi-Cal, OneCare, OneCare Connect and PACE programs in accordance with this Policy.

B. CalOptima shall ensure training of staff that interact with Members in accordance with CalOptima Policy AA.1250Δ: Disability Awareness and Sensitivity, and Cultural Competency Staff Training.

C. A Health Network shall ensure training of Health Network staff that interact with Members in accordance with this Policy.

D. Network Providers: CalOptima or a Health Network shall provide Newly Contracted Provider and annual training to Network Providers who serve CalOptima's Members participating in CalOptima's health care programs, in accordance with applicable DHCS and CMS requirements and Section III.A. of this Policy.

1. CalOptima shall require disability and cultural competency training for its Network Providers in accordance with Section III.B. of this Policy.

2. CalOptima and Health Networks shall develop and implement a process to provide information to Network Providers and to train providers on a continuing basis regarding clinical protocols and evidenced-based practice guidelines and DHCS developed cultural awareness and sensitivity instructions for Seniors and Persons with Disabilities (SPD).

   a. This process shall include an educational program for Network Providers regarding health needs specific to SPD Members that utilizes a variety of educational strategies, including

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but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

b. Individuals covered by this requirement include, but are not limited to, CalOptima and Health Network staff that interact with Members, as applicable, contracted CalOptima and Health Network Primary Care Physicians (PCPs), specialists who serve a high-volume of SPD Members, and speech, occupational, and physical therapists, in accordance with Welfare and Institutions Code section 14182(b)(5).

E. Designated County Agencies: CalOptima shall provide training to staff of designated county agencies with which CalOptima partners that interact with Members, as applicable, and in accordance with Section III.B.1. of this Policy.

F. For out-of-network Providers who will not receive Network Provider training, CalOptima or a Health Network shall develop and implement a process to provide the out-of-network Provider with clinical protocols, evidence-based practice guidelines, and the Special Needs Plan (SNP) Model of Care. CalOptima or a Health Network shall arrange to provide these protocols and guidelines at the time that CalOptima or a Health Network enters into an agreement with an out-of-network Provider.

1. CalOptima shall require disability and cultural competency training for its Network Providers in accordance with Section III.C. of this Policy.

G. PACE Providers shall complete training prior to commencement of services to PACE Participants.

H. CalOptima shall review Health Network reports to ensure compliance with Newly Contracted Provider and annual training.

I. CalOptima and each Health Network shall make a Provider Manual accessible to all Network Providers and Subcontractors.

J. Training attestations shall be required as provided in Sections III.E-F. of this Policy.

K. For purposes of this policy, the Newly Contracted Provider training and annual training are referred to as separate and distinct trainings due to the timeframe requirements for each training. The content included in Newly Contracted Provider training and annual training is the same.

III. PROCEDURE

A. Newly Contracted Provider Training

1. Newly Contracted Provider and Annual Training for Network Providers shall be provided as follows:

a. CalOptima or Health Network shall initiate training for all Network Providers and Subcontractors no later than ten (10) working days and shall complete the training within thirty (30) calendar days of placing them on Active Status.

b. Training materials shall include, but are not limited to the following:

i. Training agenda;

ii. Training presentation;

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iii. Training handouts;

iv. Applicable CalOptima or Health Network resource and contact information;

v. Attendance roster;

vi. Training attestation; and

vii. Training evaluation form.

2. Health Networks shall attest that appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness and sensitivity instructions for SPDs in accordance with Welfare and Institutions Code section 14182(b)(5).

3. CalOptima shall provide training on key elements of operating a successful program for administering Managed Long-Term Services and Supports (MLTSS).

4. Upon completion of the training, the Network Provider shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima or the Health Network.

5. If CalOptima or a Health Network is unable to complete the training within the thirty (30) calendar day requirement, CalOptima or Health Network shall send materials to the Network Provider's office, and document reasons and actions taken due to non-completion of the training.

6. CalOptima and its Health Networks shall track completion of the Network Provider's training, including the date of completion of the training.

7. A Health Network shall submit a completed Health Network Newly Contracted Provider Office Training Report to CalOptima on a quarterly basis, on or before the twenty-fifth (25th) day of the month, following the end of the quarter. If the twenty-fifth (25th) day falls on a non-business day, the Health Network shall submit the report no later than the next business day.

8. CalOptima or a Health Network shall retain training records for a period of at least ten (10) years.

B. Network Provider and Subcontractor Annual Training

1. CalOptima or Health Networks shall provide annual training for Network Providers and Subcontractors:

a. Annual training required one time per year;

b. When conducting Provider forums, meetings, outreach visits;

c. When determined necessary through notification to Providers of newly contracted product lines or updates to existing product services, performance data, such as complaint and grievance data, Member and Provider satisfaction and accessibility surveys, and practices serving a high volume of targeted populations;

d. Upon request from Providers; and

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e. When CalOptima or one of its regulators determines that a Provider has discriminated against a CalOptima Member.

C. Newly Contracted Provider Training and Annual Training Material

1. As specified in Attachment B, Newly Contracted Provider training and annual training will include, at a minimum:

a. CalOptima programs and initiatives, including but not limited to, the California Advancing and Innovating Medi-Cal (CalAIM) and the Whole-Child Model (WCM) program;

b. CalOptima/Health Network operations;

c. Provider communications;

d. Member rights and responsibilities;

e. CalOptima policies and procedures;

f. Individual Health Education Behavioral Assessment (IHEBA) contract requirements;

g. Member benefits;

h. Claims submission and payment;

i. Coordination of benefits;

j. Conflict resolution;

k. Critical incident reporting;

l. Member Grievance and Appeals process;

m. Member billing restrictions;

n. Utilization Management Appeals and Provider dispute resolution process;

o. Prior authorization process;

p. Medical management and authorization requirements;

q. Customer service, cultural and linguistic requirements and cultural competency training;

r. Community Based Adult Services;

s. Behavioral Health;

t. Medical management delegation and payment responsibility;

u. Medi-Cal and Medicare Member eligibility verification and disenrollment process;

v. Seniors and Persons with Disabilities (SPD) trainings;

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w. Fraud, Waste, and Abuse and compliance training;

x. OneCare Connect Program Overview;

y. Model of Care;

z. Access standards;

aa. Subcontract Network Certification requirements;

bb. Reporting requirements;

cc. Long-Term Support Services (LTSS);

dd. Authorizations, claims and Member eligibility verification process for hospitals, skilled nursing facilities and ancillary providers;

ee. Disability training information, including, but not limited to, the following:

i. Chronic conditions prevalent within the population;

ii. Awareness of personal prejudices;

iii. Legal obligations to comply with the Americans Disability Act (ADA) and Section 504 of the Rehabilitation Act;

iv. Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs;

v. Types of barriers encountered by the target population;

vi. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles, and the recovery model;

vii. Working with Members with mental health diagnoses, including crisis prevention and treatment;

viii. Working with Members with substance use conditions, including diagnosis and treatment; and

ix. HIV stigma and non-discrimination requirements;

ff. Quality improvement for health services programs;

gg. Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+) cultural competency training;

hh. Use of culturally competent practices and access to services in a culturally competent manner for all Members regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and

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i. Use of clinical protocols, evidence-based practices, and specific levels of quality outcomes.

D. Provider Manual Requirements

1. CalOptima or a Health Network shall make a Provider Manual accessible to all Network Providers and Subcontractors. The Provider Manual shall include, at a minimum, the following information:

a. Updates and revisions;

b. Overview and Model of Care;

c. CalOptima or Health Network contact information;

d. Member benefits covered by CalOptima;

e. Eligibility determination and verification process;

f. Quality improvement for health services programs;

g. Member rights and responsibilities;

h. Provider billing and reporting;

i. The Member problem resolution process;

j. The authorization process;

k. Provider cultural and linguistic requirements;

l. Regulatory and contractual requirements; and

m. Other activities and services needed to assist Members in optimizing their health status, including assistance with self-management skills or techniques, health education, and other modalities to improve health status.

E. Health Network Training Materials

1. By or before January 15 of each year, Health Networks shall attest that all Health Network Providers participating with CalOptima and Health Networks, have completed, attested, and retained such records of Newly Contracted Provider and Annual Training located on CalOptima's website www.caloptima.org. Training materials to include the following:

a. OneCare Connect Program Overview;

b. Cultural Competency Training;

c. Disability Awareness Training;

d. OneCare Model of Care; and

e. Fraud, Waste and Abuse Training.

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F. Training Attestations Requirements

1. Training attestations are required for:

   a. Health Networks, Network Providers, Subcontractors, and all personnel that completed CalOptima's training.

      i. All staff who interact or potentially interact with Medi-Cal, OneCare, OneCare Connect Members, and SPD beneficiaries;

      ii. All staff who are responsible for policies and procedures affecting Medi-Cal, OneCare, OneCare Connect members and Seniors and Persons with Disabilities beneficiaries; and

      iii. Any other staff deemed appropriate by CalOptima, CMS or DHCS.

   b. A Health Network, Network Provider or Subcontractor shall provide the following information on the training attestation:

      i. Organization name;

      ii. Date of completed training;

      iii. Name of individual attesting; and

      iv. Signature of individual attesting.

   c. CalOptima Provider Relations Department shall validate that the following requirements are met:

      i. Training for all Network Providers is initiated no later than ten (10) working days after CalOptima places a newly contracted Network Provider on Active Status and completed within thirty (30) calendar days of placing on Active Status;

      ii. A signed attestation is obtained from the Network Provider; and

      iii. Health Networks shall submit Newly Contracted Provider and annual training reports pursuant to CalOptima Policy HH.2003Δ: Health Network and Delegated Entity Reporting. The Newly Contracted Provider and annual training reports on the reporting grid reflect the reporting submission requirements.

G. Health Network and Delegated Entity Reporting

1. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima as required by CalOptima or as specified in its contract or CalOptima's policies and procedures in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

2. CalOptima Provider Relations Department shall be accountable for:

   a. Identifying required reports;

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b. Ensuring that all reports list all applicable regulatory, contractual, and policy citations and include all required data elements;

c. Creating templates and all applicable reporting formats, instructions, and technical guidelines;

d. Monitoring submission and timeliness of reports;

e. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

f. Notifying Health Network Relations of unsuccessful follow-up attempts; and

g. Escalating issues of continued noncompliance to the Office of Compliance.

3. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima's Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

4. The Office of Compliance shall be responsible for annual audit of CalOptima and Health Networks provider training in accordance with CalOptima Policy GG.1619: Delegation Oversight.

H. Verification of Network Provider Training

1. CalOptima and Health Networks shall verify that Network Providers attest to Newly Contracted Provider and annual training.

2. Verification

a. On a quarterly basis, CalOptima shall obtain Newly Contracted Provider and annual training attestations from Health Networks and CalOptima Community Network (CCN).

b. Health Networks and CCN shall document the outcome of each attempt to obtain Newly Contracted Provider and Annual Training attestations.

c. CalOptima shall monitor training attestation compliance annually in accordance with this Policy.

IV. ATTACHMENT(S)

A. Newly Contracted Provider and Annual Training
B. Provider Network Training Descriptions

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Policy AA.1250Δ: Disability Awareness and Sensitivity, and Cultural Competency Staff Training.
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting

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H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. Medicare Managed Care Manual, Chapter 5, Section 20.2.2, MOC 3, Element C, Factors 1 and 2
J. Title 42, Code of Federal Regulations (CFR), §§422.101(f)(2)(ii), 438.3(u), 438.206(c)(2), 438.236(c), and 438.414
K. Welfare and Institutions (W&I) Code, §14182 (b)(5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/29/2010	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2001	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	07/01/2007	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	01/01/2009	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	11/01/2012	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	03/01/2015	EE.1103Δ	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2015	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2016	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	03/07/2019	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	EE.1103Δ	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	EE.1103Δ	Provider Network Training	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with CalOptima, or a Health Network. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within that group.
Appeal	Medi-Cal: A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a Covered Service. Includes a request for a fair hearing in accordance with California Code or Regulations (CCR) Titled 22, Section 51014 and Welfare and Institutions Code section 10950. OneCare and OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review. PACE: A Participant's action taken with respect to the CalOptima PACE's non-coverage of, or nonpayment for, a service, including denials, reductions or termination of services. An Appeal may be filed verbally, either in-person or by telephone, or in writing. The Appeal process may take one (1) of two (2) forms: 1. Standard Appeal: A standard review process for response to and resolution of an Appeal as expeditiously as the Participant's health requires, but no later than thirty (30) days after the CalOptima PACE receives an Appeal. 2. Expedited Appeal: When a Participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute. CalOptima PACE shall respond to the Appeal as expeditiously as the Participant's health condition requires, but no later than seventy-two (72) hours after it receives the Appeal. The seventy-two (72)-hour timeframe may be extended by up to fourteen (14) calendar days for either of the following reasons: a. The Participant requests the extension; or b. The PACE organization justifies to the State administering agency the need for additional information, and how the delay is in the interest of the Participant.
California Advancing and Innovating Medi-Cal (CalAIM)	A multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.

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Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, C alifornia Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Direct - Administrative	The managed Fee-For-Service health care program operated by CalOptima that provides services to Members who meet certain eligibility criteria as described in CalOptima Policy DD.2006 Enrollment in/Eligibility with CalOptima Direct.
Chronic Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Centers for Medicare & Medicaid Services (CMS)	A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Community Based Adult Services (CBAS)	Offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.
Critical Incident	Critical incident refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Department of Healthcare Services (DHCS)	A department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs.
Delegated Entity	For purposes of this policy, a Delegated Entity is contracted with CalOptima to provide covered services to eligible CalOptima Members including but not limited to medical, dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Members.
Grievance	Medi-Cal: An expression of dissatisfaction about any matter other than an adverse benefit determination. OneCare and OneCare Connect: Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action. PACE: A complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of Participant care. A Grievance may include, but is not limited to: 1. The quality of services a Participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility); 2. Waiting times on the telephone, in the waiting room or exam room; 3. Behavior of any of the care providers or PACE employees; 4. Adequacy of center facilities; 5. Quality of the food provided; 6. Transportation services; and 7. A violation of a Participant's rights.

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Term	Definition
Health Network	For purposes of this policy, 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 to provide Covered Services to Members assigned to that Health Network.
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Member	A beneficiary enrolled in a CalOptima program.
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Participant	An individual enrolled in the CalOptima PACE program.
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Annual Provider Training Report
Date Due:

Health Network/Vendor Name:
Year:
Prepared by:
Phone:

As required by CalOptima policy EE.1103: Provider Network Training, CalOptima or a Health Network/Vendor shall provide annual training to all contracted Providers who serve CalOptima's Members participating in CalOptima's health care programs. Additionally, CalOptima will provide training to appropriate staff of designated county agencies with which CalOptima partners.

Provider Name(s)	Provider NPI	Tax ID	Group Name	Group NPI	Medi-Cal	OneCare	OneCare Connect	OneCare Model of Care Training	HN Annual Education	Effective Date of Active Status	Date Training Conducted	Date Completed (training no later than thirty (30) calendar days)	Signed Acknowledgement Received (Y/N)	Comments/Explanation of Missed Deadline(s)

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Attachment B: ~~EE.1103A:~~ Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
Access Standards	~~The training~~ Includes information~~educates contracted Providers and Health Networks~~ on the expectation of appointment, telephone access, provider availability and linguistic service standards.	~~Annually~~Annually ~~Annually~~ Initial and Annual~~and Ongoing~~	EE.1103Δ: Provider Network Training (Section III.C.1.z.) ~~and III.D.1.m.)~~
Authorization Process	~~The training~~Includes details ~~educates contracted providers and health networks~~ on how to submit authorization requests, what classifies as an urgent authorization request and how to complete an Authorization Request Form (ARF).	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Sections ~~III.EB.15., III.D.1.j. and III.E.10.)~~C.1.dd.) CalOptima Provider Manual (Section F)
Behavioral Health	Includes information~~Behavioral Health Providers are educated~~on CalOptima's ~~D~~delivery ~~M~~model, member eligibility, behavioral health clinical operations, authorization requirements, claims processing and how to locate resources on the CalOptima website.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Sections ~~III.C.~~1.s.) ~~and III.D.1.h.)~~
CalOptima Policies and Procedures	Describes~~Providers and Health Networks are educated on~~ where to locate CalOptima's Policies and Procedures on the CalOptima website.	Initial and Annual~~Annually and Ongoing~~	EE.1103Δ: Provider Network Training (Section III.C.~~.~~1.e~~5~~.)
CalOptima/-Health Network Operations	~~The training i~~Includes an overview of CalOptima's contractual relationship with Health Networks to assist contracted providers in understanding CalOptima and the Health Network's daily operations.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1~~2~~.b.)

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
CalOptima Programs and Initiatives	Includes an overview of CalOptima's programs: Medi-Cal, OneCare, OneCare Connect and PACE, as well as ~~and~~ initiatives, including but not limited to the California Advancing and Innovating Medi-Cal (CalAIM), Whole-Child Model and (WCM) program.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.a.)
Claims Submission and Payment	Includes ~~Providers and Health Networks are educated~~information on CalOptima's data clearinghouses used to submit claims and process payments. CalOptima is contracted with two (2) data clearinghouses (Emdeon and Office Ally) that receive and transmit EDI (Electronic Data Interchange) claims to CalOptima.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.~~C~~8.1.h.)
Community Based Adult Services (CBAS)	~~The training i~~Includes an overview of topics related to CBAS such as provider registration (~~-~~as CBAS providers rendering services to CalOptima members must be registered in CalOptima's system), eligibility verification, prior authorization, case management, claims and billing guidelines, and grievances and appeals processes.	Initial and Annual~~Annually and Ongoing~~	EE.1103Δ: Provider Network Training (Section III.~~B~~CD.1.r.~~g~~.)

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
Conflict Resolution	Includes details on a member's right to file a grievance with the Health Network or CalOptima in order to resolve any conflict/grievance and obtain resolution for ~~In the~~ instances of conflict between members and providers, members and a Health Network or members in CalOptima~~, members may file a grievance with the Health Network or CalOptima in order to resolve any conflict/ grievance and obtain resolution~~. In the instance of conflict between providers and members, providers and a Health Network or providers in CalOptima, providers may file a grievance with the Health Network or CalOptima in order to resolve any conflict/-grievance and obtain resolution.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.j.~~,~~)
Coordination of Benefits	~~Training i~~Includes an overview of the CalOptima programs and the services and/or benefits that are covered under each program.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.i)
Critical Incident Reporting	Includes an overview of how to report compliance violations such as HIPAA violations, review of laws and regulations providers are mandated to follow,~~;~~ consequences and penalties,~~;~~ and correcting reporting errors.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.k)

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
Customer Service & Cultural Competency Training	~~Providers and Health Networks are educated on the~~Includes information on the ~~T~~three (3) pillars of Cultural Competence: 1) language access services;~~,~~ 2) culturally competent care; 3)~~,~~ and organizational support, as well as ~~.~~ ~~Providers and Health Networks are educated on~~ how to contact CalOptima's Customer Service Department.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section ~~sII.L.2.~~ III.~~D~~CB.1.q~~. and III.D.1.a.~~) CalOptima Provider Manual Section N
Disability Training	Includes information on prevalent chronic conditions in the population, legal obligations to comply with the American Disability A~~CT~~ct (ADA), Section 504 of the Rehabilitation Act, and the use of culturally competent practices regardless of disability.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section~~s~~ III.C~~L~~.13~~. and I~~.ee.)
~~Eligibility Determination and Verification Process~~	~~Provider and Health Networks are educated~~Includes ~~information on how to check mMember eligibility using CalOptima Link and the Interactive Voice Response (IVR) System. Providers may use these systems to verify a mMember's Medi-Cal, OneCare (HMO SNP) or OneCare Connect eligibility.~~	Initial and Annual	~~EE.1103Δ: Provider Network Training (Section II.E.)~~ ~~CalOptima Provider Manual Section E~~
Fraud, Waste, and Abuse (FWA) and Compliance Training	~~This training i~~Includes an overview of how the compliance program operates, how to report compliance program violations, and concepts such as laws and regulations,~~;~~ consequences and penalties,~~;~~ and preventing, reporting, and correcting FWA.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section ~~s II.L.5.~~ III.C~~B~~.1.2w3~~. andI.~~.) CalOptima Provider Manual Section P

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
Individual Health Education Behavioral Assessment (IHEBA) Contract Requirements	Includes information and details on the ~~The~~ California Department of Health Care Services (DHCS) requirement for~~s~~ primary care providers to administer a Staying Healthy Assessment (SHA) or approved alternate Individual Health Education Behavioral Assessment (IHEBA) ~~on~~to all Medi-Cal managed care members within one hundred twenty (120) days of enrollment with CalOptima and again at defined intervals. ~~Providers and Health Networks are educated on the Staying Healthy Assessment.~~	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.f.)
Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+) cultural competent training;	Includes information and resources for providers on access services, culturally competent care, and organizational support for the LGBTQIA+ members.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.gg.)
Long-Term Support Services (LTSS)	Includes information on a wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.cc.)
Medi-Cal and Medicare Member Eligibility Determination and Verification Process	Includes information on how to check Member eligibility using CalOptima Link and the Interactive Voice Response (IVR) System. Providers may use these systems to verify a Member's Medi- Cal, OneCare (HMO SNP) or OneCare Connect eligibility.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.u.) CalOptima Provider Manual Section E
Medical Management and Authorization Requirements	~~The training i~~Includes information on how to obtain and submit prior authorization, what services qualify for authorization, and what cases qualify for case management.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.~~1p6.~~) CalOptima Provider Manual Section G

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
Medical Management Delegation and Payment Responsibility	~~The training i~~Includes information on the authorization process, what services qualify for authorization, and which entity (CalOptima or a delegated entity/ Health Network) may be ~~th~~financially~~e payment~~ responsibility ~~of CalOptima and delegated entit~~for payment of services.~~ies.~~	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Sections~~s~~ III.C.1.t~~20. and III.D.1.i.16~~) CalOptima Provider Manual Section G
Member ~~b~~Benefits	~~Providers and Health Networks are educated on~~Includes detail on where to locate~~d~~ resources regarding ~~m~~Member benefit information on the CalOptima website.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.g.) CalOptima Provider Manual Section N
Member Billing Restrictions	~~Providers and Health Networks are~~Includes information ~~informed that~~ that ~~the~~ DHCS prohibits providers from charging ~~m~~Members for Medi-Cal covered services or having any recourse against the ~~m~~Member for Medi-Cal covered services rendered to the ~~m~~Member.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.m.~~.~~)
~~Annually and s III.B.21., III.D.1.j. and I.~~Member Grievance and Appeals process	~~Training i~~Includes an overview of the process CalOptima uses to address and resolve Member ~~G~~grievances in accordance with applicable statutory, regulatory, and contractual requirements.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.~~l~~l.)

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
Member Rights and Responsibilities	~~Providers and Health Networks are educated~~Includes information on how CalOptima informs its ~~m~~Members of their rights and responsibilities, ~~and~~ ensures that ~~m~~Members' rights and responsibilities are respected and observed, and ~~. Provider and Health Networks are also educated on~~ how to locate the list of ~~m~~Members' rights and responsibilities on the website and in Provider Manual.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Sections~~ and III.E.7.~~ III.C.1.d.) CalOptima Provider Manual Section N
Model of Care	Learn the goals of CalOptima programs and their key components including an overall description of the Special Needs Plan (SNP) populations, care coordination, the provider network, and quality measurement and performance improvement.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Sections~~ II.L.4.~~ III.C.1.y.)~~, and III.D.1.e.)~~

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
OneCare Connect Program Overview	~~The training will i~~Includes an overview of CalOptima's OneCare Connect (OCC) program and the variety of benefits and services available to ~~m~~Members. Topics include an overview of ~~B~~behavioral ~~H~~health, ~~m~~Member~~-~~-enrollee services, the grievances and appeals process, the roles of an Interdisciplinary Care Team (ICT), and how the components of the program interact to meet ~~m~~Member needs. The training objectives include: 1) Having awareness and knowledge about CalOptima's OneCare Connect Program for ~~m~~Members in Orange County who are eligible for Medicare and Medi-Cal; 2) Being aware of the variety of benefits and services available to the ~~m~~Member; and 3) Knowing where to go to obtain more information about OneCare Connect benefits and resources.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Sections ~~II.I.1.,~~III.C.1.x.~~), III.D.1.d.)~~
Prior Authorization Process	~~Training i~~Includes information on how to obtain and submit prior authorization for outpatient and routine services. Training also explains how to complete an Authorization Request Form (ARF) for urgent and inpatient authorization requests.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.o.)

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
Provider Communications	~~Providers and Health Networks are educated~~Includes details on the types of provider communications CalOptima offers, including ~~. Said communications include~~ monthly Provider Updates, Provider Newsletters and where to locate Provider communications on the CalOptima website.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.c)
Provider Cultural and Linguistic Requirements	~~Providers and Health Networks are~~Includes information~~ed~~ about the state and federal regulations that require CalOptima to make interpreter and translation services for limited English proficient (LEP) members available.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.q.) CalOptima Provider Manual Section N
Provider Manual	Describes where to locate CalOptima's Provider Manual on the CalOptima website. The Provider Manual is a communication tool and reference guide containing basic information for providers to learn how to work with CalOptima.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.D.)
Quality ~~i~~Improvement for ~~h~~Health S~~s~~ervices ~~p~~Programs	~~Provider and Health Networks are educated~~Includes information on ~~A~~access S~~s~~tandards for all CalOptima programs, how to report quality of care issues, HEDIS Measures and Reporting, how to complete an Initial Health Assessment (IHA) and guidance on the Facility Site Review (FSR), Medical Records Review and Physical Accessibility Review.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.ff.) CalOptima Provider Manual Section N

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	~~Policy~~ Reference(s)
Reporting R~~r~~equirements	~~Providers and Health Networks are educated~~Includes information on reporting requirements that include identifying required reports, the required data elements, monitoring submissions, timeliness of reports, the notification process of missing, incorrect, or late reports, and the Corrective Action Plan (CAP) process for reported issues of noncompliance with reporting.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Sections~~II.N.1. and~~ III.C.1.bb.)
Seniors and People with Disabilities (SPD) training	~~The training i~~Includes a review of the Accommodation Checklist, an overview of the Deaf and Disabled Telecommunications Program (DDTP), disability etiquette, and learning how to communicate and interact with people who have disabilities.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Sections III.C~~B~~.1~~22~~.v.) ~~and I..)~~ CalOptima Provider Manual Section N
Subcontracted Network Certification Requirements	~~Providers and Health Networks are provided~~Includes guidance on Annual Network Certification (ANC) requirements in accordance ~~to~~with DHCS ~~regulations~~requirements.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1~~.~~.aa.)
Utilization Management (UM) Appeals and Provider dispute resolution process	~~The training i~~Includes information on how to file an appeal for UM authorization decisions and how to submit a Provider Dispute Resolution (PDR) to review a contested claim.	Initial and Annual~~Annually and~~	EE.1103Δ: Provider Network Training (Section III.C.1.n.~~.~~)

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Training Topic	Training Description	Training Frequency	Reference(s)
Access Standards	Includes information on the expectation of appointment, telephone access, provider availability and linguistic service standards.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.z.)
Authorization Process	Includes details on how to submit authorization requests, what classifies as an urgent authorization request and how to complete an Authorization Request Form (ARF).	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.dd.) CalOptima Provider Manual (Section F)
Behavioral Health	Includes information on CalOptima's delivery model, member eligibility, behavioral health clinical operations, authorization requirements, claims processing and how to locate resources on the CalOptima website.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.s.)
CalOptima Policies and Procedures	Describes where to locate CalOptima's Policies and Procedures on the CalOptima website.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.e.)
CalOptima/Health Network Operations	Includes an overview of CalOptima's contractual relationship with Health Networks to assist contracted providers in understanding CalOptima and the Health Network's daily operations.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.b.)
CalOptima Programs and Initiatives	Includes an overview of CalOptima's programs: Medi-Cal, OneCare, OneCare Connect and PACE, as well as initiatives, including but not limited to the California Advancing and Innovating Medi-Cal (CalAIM), Whole-Child Model and (WCM) program.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.a.)

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Training Topic	Training Description	Training Frequency	Reference(s)
Claims Submission and Payment	Includes information on CalOptima's data clearinghouses used to submit claims and process payments. CalOptima is contracted with two (2) data clearinghouses (Emdeon and Office Ally) that receive and transmit EDI (Electronic Data Interchange) claims to CalOptima.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.h.)
Community Based Adult Services (CBAS)	Includes an overview of topics related to CBAS such as provider registration (as CBAS providers rendering services to CalOptima members must be registered in CalOptima's system), eligibility verification, prior authorization, case management, claims and billing guidelines, and grievances and appeals processes.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.r.)
Conflict Resolution	Includes details on a member's right to file a grievance with the Health Network or CalOptima in order to resolve any conflict/grievance and obtain resolution for instances of conflict between members and providers, members and a Health Network or members in CalOptima. In the instance of conflict between providers and members, providers and a Health Network or providers in CalOptima, providers may file a grievance with the Health Network or CalOptima in order to resolve any conflict/grievance and obtain resolution.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.j.)

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Training Topic	Training Description	Training Frequency	Reference(s)
Coordination of Benefits	Includes an overview of the CalOptima programs and the services and/or benefits that are covered under each program.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.i)
Critical Incident Reporting	Includes an overview of how to report compliance violations such as HIPAA violations, review of laws and regulations providers are mandated to follow, consequences and penalties, and correcting reporting errors.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.k)
Customer Service & Cultural Competency Training	Includes information on the three (3) pillars of Cultural Competence: 1) language access services; 2) culturally competent care; 3) and organizational support, as well as how to contact CalOptima's Customer Service Department.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.q.) CalOptima Provider Manual Section N
Disability Training	Includes information on prevalent chronic conditions in the population, legal obligations to comply with the American Disability Act (ADA), Section 504 of the Rehabilitation Act, and the use of culturally competent practices regardless of disability.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.ee.)
Fraud, Waste, and Abuse (FWA) and Compliance Training	Includes an overview of how the compliance program operates, how to report compliance program violations, and concepts such as laws and regulations, consequences and penalties, and preventing, reporting, and correcting FWA.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.w.) CalOptima Provider Manual Section P

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	Reference(s)
Individual Health Education Behavioral Assessment (IHEBA) Contract Requirements	Includes information and details on the California Department of Health Care Services (DHCS) requirement for primary care providers to administer a Staying Healthy Assessment (SHA) or approved alternate Individual Health Education Behavioral Assessment (IHEBA) to all Medi-Cal managed care members within one hundred twenty (120) days of enrollment with CalOptima and again at defined intervals.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.f.)
Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+) cultural competent training;	Includes information and resources for providers on access services, culturally competent care, and organizational support for the LGBTQIA+ members.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.gg.)
Long-Term Support Services (LTSS)	Includes information on a wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.cc.)
Medi-Cal and Medicare Member Eligibility Determination and Verification Process	Includes information on how to check Member eligibility using CalOptima Link and the Interactive Voice Response (IVR) System. Providers may use these systems to verify a Member's Medi- Cal, OneCare (HMO SNP) or OneCare Connect eligibility.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.u.) CalOptima Provider Manual Section E
Medical Management and Authorization Requirements	Includes information on how to obtain and submit prior authorization, what services qualify for authorization, and what cases qualify for case management.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.p.) CalOptima Provider Manual Section G

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Training Topic	Training Description	Training Frequency	Reference(s)
Medical Management Delegation and Payment Responsibility	Includes information on the authorization process, what services qualify for authorization, and which entity (CalOptima or a delegated entity/ Health Network) may be financially responsibility for payment of services.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.t.) CalOptima Provider Manual Section G
Member Benefits	Includes detail on where to locate resources regarding Member benefit information on the CalOptima website.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.g.) CalOptima Provider Manual Section N
Member Billing Restrictions	Includes information that DHCS prohibits providers from charging Members for Medi-Cal covered services or having any recourse against the Member for Medi-Cal covered services rendered to the Member.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.m.)
Member Grievance and Appeals process	Includes an overview of the process CalOptima uses to address and resolve Member grievances in accordance with applicable statutory, regulatory, and contractual requirements.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.l.)
Member Rights and Responsibilities	Includes information on how CalOptima informs its Members of their rights and responsibilities, ensures that Members' rights and responsibilities are respected and observed, and how to locate the list of Members' rights and responsibilities on the website and in Provider Manual.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.d.) CalOptima Provider Manual Section N

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Training Topic	Training Description	Training Frequency	Reference(s)
Model of Care	Learn the goals of CalOptima programs and their key components including an overall description of the Special Needs Plan (SNP) populations, care coordination, the provider network, and quality measurement and performance improvement.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.y.)
OneCare Connect Program Overview	Includes an overview of CalOptima's OneCare Connect (OCC) program and the variety of benefits and services available to Members. Topics include an overview of behavioral health, Member-enrollee services, the grievances and appeals process, the roles of an Interdisciplinary Care Team (ICT), and how the components of the program interact to meet Member needs. The training objectives include: 1) Having awareness and knowledge about CalOptima's OneCare Connect Program for Members in Orange County who are eligible for Medicare and Medi-Cal; 2) Being aware of the variety of benefits and services available to the Member; and 3) Knowing where to go to obtain more information about OneCare Connect benefits and resources.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.x.)
Prior Authorization Process	Includes information on how to obtain and submit prior authorization for outpatient and routine services. Training also explains how to complete an Authorization Request Form (ARF) for urgent and inpatient authorization requests.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.o.)

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Training Topic	Training Description	Training Frequency	Reference(s)
Provider Communications	Includes details on the types of provider communications CalOptima offers, including monthly Provider Updates, Provider Newsletters and where to locate Provider communications on the CalOptima website.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.c)
Provider Cultural and Linguistic Requirements	Includes information about the state and federal regulations that require CalOptima to make interpreter and translation services for limited English proficient (LEP) members available.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.q.) CalOptima Provider Manual Section N
Provider Manual	Describes where to locate CalOptima's Provider Manual on the CalOptima website. The Provider Manual is a communication tool and reference guide containing basic information for providers to learn how to work with CalOptima.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.D.)
Quality Improvement for Health Services Programs	Includes information on access standards for all CalOptima programs, how to report quality of care issues, HEDIS Measures and Reporting, how to complete an Initial Health Assessment (IHA) and guidance on the Facility Site Review (FSR), Medical Records Review and Physical Accessibility Review.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.ff.) CalOptima Provider Manual Section N

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Attachment B: Provider Network Training Descriptions

Training Topic	Training Description	Training Frequency	Reference(s)
Reporting Requirements	Includes information on reporting requirements that include identifying required reports, the required data elements, monitoring submissions, timeliness of reports, the notification process of missing, incorrect, or late reports, and the Corrective Action Plan (CAP) process for reported issues of noncompliance with reporting.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.bb.)
Seniors and People with Disabilities (SPD) training	Includes a review of the Accommodation Checklist, an overview of the Deaf and Disabled Telecommunications Program (DDTP), disability etiquette, and learning how to communicate and interact with people who have disabilities.	Initial and Annual	EE.1103Δ: Provider Network Training (Sections III.C.1.v.) CalOptima Provider Manual Section N
Subcontracted Network Certification Requirements	Includes guidance on Annual Network Certification (ANC) requirements in accordance with DHCS requirements.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.aa.)
Utilization Management (UM) Appeals and Provider dispute resolution process	Includes information on how to file an appeal for UM authorization decisions and how to submit a Provider Dispute Resolution (PDR) to review a contested claim.	Initial and Annual	EE.1103Δ: Provider Network Training (Section III.C.1.n.)

For 20220203 BOD Review Only

Policy:	EE.1114
Title:	**Health Network Notification of Change in Name, Management Company, Key Personnel, or Operating System(s)**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	/s/
Effective Date:	04/01/1996
Last Review Date:	01/01/2018
Retirement Date:	02/03/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

For 20220203 BOD Review for Retirement

I. PURPOSE

This policy describes the requirements for a Health Network or Delegated Entity to notify CalOptima of a change in the Health Network or Delegated Entity's name, management company, key personnel, or operating system(s).

II. POLICY

A. A Health Network or Delegated Entity shall submit written notification to CalOptima of a proposed change in the Health Network or Delegated Entity's name, ownership or control information, management company and/or "doing business as" (DBA) business name, in accordance with the timelines outlined in this Policy.

B. To the extent possible, a Health Network or Delegated Entity shall give prior notice to CalOptima of a change in Key Personnel.

C. A Health Network or Delegated Entity shall report all system changes that may impact operations and/or reporting in accordance with Section III.H of this Policy.

III. PROCEDURE

A. If a Health Network or Delegated Entity intends to change its name, management company, and/or doing business as (DBA), the Health Network or Delegated Entity shall submit written notification to CalOptima's Director of Contracting and copy CalOptima's Director of Health Network Relations, six (6) months in advance of such change.

B. If a Health Network or Delegated Entity undergoes a change in ownership, as outlined in Department of Health Services (DHCS) All Plan Letter 17-019: Provider Credentialing/Recredentialing and Screening/Enrollment, the Health Network or Delegated Entity shall notify CalOptima within thirty-five (35) calendar days of change in ownership.

C. Upon receipt of notification of a Health Network's or Delegated Entity's DBA change, the CalOptima Contracting and/or Health Network Relations Department shall:

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1. Send written confirmation to the Health Network or Delegated Entity indicating the date CalOptima received the Health Network or Delegate Entity's notification, anticipated required approvals, and the proposed effective date of the DBA change.

2. Contracting Department, with the assistance of the Health Network Relations and Legal Affairs Department, determine if CalOptima Board of Directors (BOD) action is required.

3. If BOD action is required, the Contracting Department shall, with the assistance of the Health Network Relations and Legal Affairs Department, notify CalOptima's Chief Executive Officer (CEO) to seek BOD approval.

4. The Health Network Relations Department shall take action as described in Section III.E. of this Policy.

D. Upon receipt of notification of a Health Network's or Delegated Entity's change in legal entity, the Contracting Department shall:

1. Determine if an assignment agreement, or new contract, is required;

2. Send written confirmation to the Health Network or Delegated Entity indicating the date CalOptima received the Health Network or Delegated Entity's notification, anticipated required approvals, and the anticipated effective date of the change in legal entity;

3. With the assistance of the Health Network Relations and Legal Affairs Department, determine if CalOptima Board of Directors (BOD) action is required;

   i. If BOD action is required, the Contracting Department shall, with the assistance of the Health Network Relations and Legal Affairs Department, notify CalOptima's Chief Executive Officer (CEO) to seek BOD approval.

4. After receipt of all required approvals, initiate required contract changes to effectuate the change in legal entity;

5. If applicable, Health Network Relations shall take action as described in Section III.E of this Policy.

E. Upon notification by a Health Network or Delegated Entity of the change in legal entity, DBA, and/or management company, the Health Network Relations Department shall:

1. Notify all CalOptima departments of legal entity, DBA, and/or management company change;

2. Develop a work plan to effectuate the change across all the applicable operational CalOptima departments, including but not limited to Customer Service, Information Services (IS), Provider Data Management Services (PDMS), and Claims Administration.

3. Notify Regulatory Affairs & Compliance Department to submit a request to the Department of Health Care Services (DHCS) to update the Automated Eligibility Verification System (AEVS) to reflect the new Health Network name.

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F. CalOptima shall review and, if necessary, amend the contract if there are ownership changes related to owners holding more percentage of the stock issued by Health Network or Delegated Entity, and major creditors holding more than percentage of the debt, as outlined in the DHCS All Plan Letter 17-019: Provider Credentialing/Recredentialing and Screening/Enrollment.

G. Notification of Health Network key management personnel changes shall be immediately submitted via email or in writing to CalOptima's Director of Network Management who shall communicate said change to appropriate the CalOptima departments

H. Subject to the provisions of this policy, a Health Network or Delegated Entity shall provide notification of system changes that may impact operations and/or reporting, including but not limited to, phone systems, email, medical management system, claims processing system, and/or any other core systems. Notification shall be submitted via the following methods:

1. For known or planned system changes, a Health Network Health Network or Delegated Entity shall notify CalOptima's Director of Network Management no later than thirty (30) calendar days prior to the effective date of the change via email or in writing.

2. In the case of unforeseen circumstances, a Health Network or Delegated Entity shall notify CalOptima's Director of Network Management upon identification or within twenty-four (24) hours of the system change via email and by telephone.

3. Upon receipt of notification from a Health Network or Delegated Entity of a change in operating system(s), CalOptima Director of Network Management shall communicate said change to the appropriate CalOptima departments.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-019: Provider Credentialing/Recredentialing and Screening/Enrollment (supersedes APL 16-002)
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/03/2022	Regular Meeting of the CalOptima Board of Directors

For 2022/2023 BOD Review for Retirement

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	EE.1114	Health Network Notification of Change in Name or Management Personnel	Medi-Cal
Revised	01/01/2002	EE.1114	Health Network Notification of Change in Name or Management Personnel	Medi-Cal
Revised	06/01/2002	EE.1114	Health Network Notification of Change in Name or Management Personnel	Medi-Cal
Revised	01/01/2007	EE.1114	Health Network Notification of Change in Name or Management Personnel	Medi-Cal
Revised	11/01/2015	EE.1114	Health Network Notification of Change in Name or Management Personnel	Medi-Cal OneCare OneCare Connect
Revised	02/01/2017	EE.1114	Health Network Notification of Change in Name, Management Company, or Key Personnel	Medi-Cal OneCare OneCare Connect
Revised	01/01/2018	EE.1114	Health Network Notification of Change in Name, Management Company, Key Personnel, or Operating System(s)	Medi-Cal OneCare OneCare Connect
RETIRED	02/03/2022	EE.1114	Health Network Notification of Change in Name, Management Company, Key Personnel, or Operating System(s)	Medi-Cal OneCare OneCare Connect

For 20220203 BOD Review for Retirement

IX. GLOSSARY

Term	Definition
Delegated Entity	For purposes of this policy, a delegated entity is contracted with CalOptima to provide dental, fitness/gym, Managed Behavioral Health Organization (MBHO), and/or vision benefits for CalOptima Members.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Key Personnel	Health network staff, including but not limited to, an officer, executive, administrator, director, or equivalent who has or can be assigned signature authority on behalf of the legal entity; who maintains a fiduciary duty on behalf of the legal entity; and/or who is responsible for plan administration, quality improvement, utilization management, customer service and/or provider relations.

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Policy:	EE.1116Δ
Title:	**Contracted Provider Notification to CalOptima of Changes Affecting the Legal Status of the Contract**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20220203 BOD Review Only

I. PURPOSE

This policy describes the process for a Contracted Provider to notify CalOptima of changes affecting the legal status of the contract.

II. POLICY

A. A Contracted Provider shall submit a written notification to the CalOptima Contracting Department of a proposed change(s) that may impact Provider's contract with CalOptima. Such changes include, but are not limited to:

1. Change of Contracted Provider's legal name or "doing business as" (dba) name;
2. Change of Ownership;
3. Change of National Provider Identifier (NPI) and/or Tax Identification Number (TIN);
4. Retirement or death of a professional that has an individual contract; and
5. Changes in availability or location of services (i.e., closure of company or location(s) that are listed in Provider's contract; new location).

B. A Contracted Provider shall give prior written notice to CalOptima in accordance with terms of their contract.

III. PROCEDURE

A. Upon receipt of notification from a Contracted Provider of changes, the Contracting Department shall:

1. Send written confirmation to the Contracted Provider indicating the date of receipt of the notification;

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2. The expected response time for the review of the changes; and

3. Request additional information from Provider, as applicable.

B. The Contracting Department shall develop a plan of action to address contract changes that need to be made, and the timeframe for such actions, when CalOptima receives a provider notification including, but not limited to, those specified in this Policy.

1. Prior to initiating contract changes, the Contracting Department shall:

a. Determine if CalOptima Board of Directors (BOD) action is required.

b. If BOD action is required, with the assistance of Legal Affairs Department and other impacted departments, as applicable, seek BOD approval including development of a CalOptima Board Action Agenda Referral (COBAR);

c. Determine if approvals from departments such as Audit & Oversight, Quality Improvement, or Medical Management are required, and obtain such approval; and

d. Notify the Health Network Relations, Provider Relations and Customer Service Departments immediately of any proposed changes that impact Primary Care Provider (PCP) Member assignments. As needed, these departments will follow their policies and procedures for any additional next steps, including required notifications to regulatory agencies and Members.

2. If the Contracting Department determines that the change(s) impacts the Contracted Provider's contract, the Contracting Department shall:

a. New Contract. Initiate a new contract in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts for changes to the Provider's legal name, NPI, or TIN. The Contracting Department shall make a best effort to align the termination date of the current contract on the effective date of the new contract to ensure continuity.

b. Assignment Agreement. Draft an Assignment Agreement for a change of ownership that does not impact the Contracted Provider's legal name, NPI, and TIN. The Quality Improvement Department shall review the Centers for Medicare & Medicaid Services (CMS) Preclusion List and other primary sources to ensure that the new owner(s) is not excluded from participation in Medicare or Medi-Cal programs.

c. Disclosure of Ownership. If applicable, send a Disclosure of Ownership Form to the Contracted Provider to complete and return to the Contracting Department for review.

d. Amendment. Draft an amendment to the Contracted Provider's current contract for changes that do not impact the Contracted Provider's legal name or TIN and are not related to a change of ownership, such as, a change in dba name, change in address that is listed in Contracted Provider's contract, addition or removal of a service location (in the case of ancillary providers) that is listed in Contracted Provider's contract.

i. If a Contracted Provider's contract lists service locations in the contract, and a Contracted Provider is requesting that a new service location be added to the contract, the Contracting Department shall submit a credentialing request to the Quality Improvement Department for the new service location. An amendment will be sent to

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Contracted Provider for signature after the Contracting Department receives notification from the Quality Improvement Department that the service location is approved.

e. Contract Termination. If the Contracted Provider's current contract will be terminated due to the changes, the Contracting Department shall send a contract termination notification letter to Provider, in accordance with the terms in Provider's contract.

3. If the Contracting Department determines that the change does not impact the contract, but may require other changes, the Contracting Department shall forward the Contracted Provider's written notification to the Provider Relations or Health Network Relations Departments, as appropriate, for processing. The Contracting Department shall notify the Contracted Provider of the results of the review via e-mail and shall include the appropriate CalOptima department's contact information for the Contracted Provider to follow-up.

4. In order to effectuate the Contracted Provider's contract change(s) across all applicable operational CalOptima departments, after a new, amended or assigned contract has been fully executed, the Contracting Department shall send an internal e-mail notification to the following departments:

   a. Behavioral Health Integration;

   b. Enterprise Analytics;

   c. Claims;

   d. Finance;

   e. Health Network Relations;

   f. Information Services;

   g. Long Term Services and Supports;

   h. Pharmacy Management;

   i. Program of All-Inclusive Care for the Elderly;

   j. Provider Data Management Services;

   k. Provider Relations;

   l. Quality Improvement;

   m. Regulatory Affairs & Compliance; and

   n. Utilization Management.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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A. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

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	04/01/1996	EE.1114	Health Network Notification of Change in Name, Management Company, Key Personnel, or Operating System(s)	Medi-Cal OneCare OneCare Connect
RETIRED	TBD	EE.1114	Health Network Notification of Change in Name, Management Company, Key Personnel, or Operating System(s)	Medi-Cal OneCare OneCare Connect
Effective	TBD	EE.1116Δ	Contracted Provider Notification to CalOptima of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Assignment Agreement	An agreement that transfers the obligations and responsibilities under a contract from the current owner to the new owner.
Change of Ownership	For purposes of this policy, a change of ownership is when there is a change of: (1) more than 25% of the ownership or equity interest in Provider; (2) more than 25% of the directors or trustees of Provider; (3) the merger, re-organization, or consolidation of Provider with another entity, with respect to which Provider is not the surviving entity; and/or (4) a change in management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (i.e., the Board of Directors) to a third-party management person, company, group, team or other entity.
Contracted Provider	For the purposes of this policy, a Contracted Provider includes but is not limited to a professional, behavioral health, ancillary, CBAS, hospital, long term care facility/skilled nursing facility, pharmacy, or Health Network that is contracted with CalOptima (via Fee-for-Service contract or capitated Delegated Entity contract) to provide covered services to CalOptima Members for one or more CalOptima program.
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 to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a Primary Care Physician or Non-Physician Medical Practitioner.

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Policy:	EE.1119
Title:	**Health Network Notification of Administrative and Operational Changes**
Department:	Network Operations
Section:	Health Network Provider Relations
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy describes the process and requirements for a Health Network or Delegated Entity to report administrative and operational changes and how such changes are effectuated by CalOptima.

II. POLICY

A. Health Networks and Delegated Entities shall notify CalOptima of administrative and operational changes in accordance with the terms and timelines outlined in this Policy.

B. For the purposes of this Policy, administrative and operational changes include, but are not limited to:

1. Changes in management service organization (MSO),
2. Changes in systems impacting operations or reporting,
3. Changes in address, phone number, or email domain, and
4. Changes in key personnel.

III. PROCEDURE

A. Changes in MSO

1. Health Networks and Delegated Entities shall notify CalOptima's Director of Network Management, via email or in writing, six (6) months in advance of an intended change in MSO.
    a. Unintended or unexpected changes in a Health Network or Delegated Entity MSO shall be communicated to CalOptima's Director of Network Management as soon as practicable.
2. Upon notification by a Health Network or Delegated Entity of an intended change in MSO:
    a. CalOptima's Health Network Relations Department shall notify all impacted CalOptima departments of the Health Network or Delegated Entity's proposed change in MSO,

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including, but not limited to, the Regulatory Affairs & Compliance, Audit & Oversight, and Information Services Departments.

b. CalOptima's Audit & Oversight (External) Department shall determine if a Readiness Assessment is required and seek appropriate approvals from the Audit & Oversight Committee (AOC) and Compliance Committee to move forward with the proposed change in MSO, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

i. Notification of committee approval or denial of the intended change in MSO shall be communicated to the requesting Health Network or Delegated Entity in accordance with CalOptima Policy GG.1619: Delegation Oversight.

3. CalOptima's Health Network Relations Department shall:

a. Work with impacted departments to operationalize the change in MSO, including but not limited to:

i. Reviewing and modifying accessibility to the Health Network or Delegated Entity's secure file transport protocol (SFTP), as appropriate,

ii. Reviewing inbound and outbound reporting between CalOptima and the Health Network or Delegated Entity, and

iii. Updating Health Network or Delegated Entity administrative contacts.

b. Request project management resources, as appropriate, to support necessary transitions or testing required to effectuate changes in Health Network or Delegated Entity MSO.

B. Changes in Systems or Migrations Impacting Operations or Reporting

1. Subject to the provisions of this Policy, a Health Network or Delegated Entity shall provide notification of system changes or migrations that may impact operations or reporting, including but not limited to:

a. Changes impacting phone systems, email servers or vendor(s), medical management/electronic health record (EHR) systems, utilization management systems, claims processing systems, and/or any other core systems.

b. Migrations or changes in the location of data servers that require one or more Health Network or Delegated Entity systems to go offline.

2. Notification of changes in systems or migrations shall be submitted to CalOptima as follows:

a. For known or planned system changes, a Health Network or Delegated Entity shall notify CalOptima's Director of Network Management no later than ninety (90) calendar days prior to the effective date of the change by email or mail.

b. In the case of unforeseen circumstances, a Health Network or Delegated Entity shall notify CalOptima's Director of Network Management upon identification of the change or within twenty-four (24) hours of the system change or migration via email and by telephone.

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c. Notification shall include an overview of the identified system change or migration, specific operating and/or reporting system impacted by the change, and any impact to existing reporting or contractual requirements between CalOptima and the Health Network or Delegated Entity.

i. System changes that result in non-compliance with CalOptima policies, regulatory requirements, and/or contractual requirements may be escalated to CalOptima's Regulatory Affairs & Compliance Department for review and determination of necessary compliance actions, up to and including sanctions, in accordance with CalOptima Policy HH.2005: Corrective Action Plan.

3. Upon receipt of notification from a Health Network or Delegated Entity of a change in operating system(s) or migration, CalOptima's Health Network Relations Department shall forward the notification of change to impacted CalOptima departments, including but not limited to the Audit & Oversight, Claims Administration, Customer Service, and Information Services Departments.

a. Following notification by the Health Network Relations Department of a Health Network's proposed system change or migration, the Audit & Oversight Department shall determine if a Readiness Assessment is required as a result of the identified system change(s) or migration.

b. The Health Network Relations Department shall request project management resources, as appropriate, to support necessary transitions or testing required to effectuate changes in Health Network or Delegated Entity systems impacting operations or reporting.

C. Changes in Address, Phone Number, or Email Domain

1. The following Health Network or Delegated Entity changes shall be communicated to the Director of Network Management no later than sixty (60) calendar days prior the effective date of such change:

a. Administrative address(es), including remittance address(es) for claims or medical service authorizations.

b. Phone number(s), including phone numbers for claims, medical service authorizations, or specific programs (e.g., Whole Child Model member/provider phone numbers).

c. Email domain.

2. Upon receipt of notification from a Health Network or Delegated Entity of a change in address, phone number, or email domain, CalOptima's Health Network Relations Department shall communicate the change to impacted CalOptima departments, including the Customer Service, Information Services (IS), Case Management, Claims Administration, Provider Data Management Services (PDMS), Regulatory Affairs & Compliance Department, Audit & Oversight, and Provider Relations Departments.

a. The Regulatory Affairs & Compliance Department shall submit a request to the Department of Health Care Services (DHCS) to update the Automated Eligibility Verification System (AEVS) to reflect the new Health Network or Delegated Entity phone number, if appropriate.

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b. CalOptima's Health Network Relations Department shall coordinate with other CalOptima departments to update:

i. The Health Network and Delegated Entity contact database maintained by CalOptima Health Network Relations;

ii. Health Network and Delegate profiles; and

iii. External-facing meeting materials, including but not limited to the Provider Manual, Provider Directory, and CalOptima website.

D. Changes in Key Personnel

1. Health Networks and Delegated Entities shall notify the Director of Network Management, via email or in writing, of changes in Key Personnel as soon as practicable but no later than the effective date of the change.

2. Upon receipt of notification from a Health Network or Delegated Entity of a change in Key Personnel, the Health Network Relations Department shall communicate Health Network and Delegated Entity Key Personnel changes to CalOptima impacted departments, including but not limited to the Audit & Oversight, Case Management, Quality Improvement, and Finance Departments.

3. To ensure business continuity, CalOptima's Health Network Relations Department shall update Health Network or Delegated Entity contact information, including but not limited to:

a. The Health Network and delegate contact database maintained by CalOptima Health Network Relations;

b. Health Network and delegate profiles; and

c. External-facing meeting materials or communications, as applicable.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Three-Way Contract with the Centers of Medicare & Medicaid Services (CMS)
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.2005Δ: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	EE.1114	Health Network Notification of Change in Name, Management Company, Key Personnel or Operating System(s)	Medi-Cal OneCare OneCare Connect
RETIRED	TBD	EE.1114	Health Network Notification of Change in Name, Management Company, Key Personnel or Operating System(s)	Medi-Cal OneCare OneCare Connect
Effective	TBD	EE.1119	Health Network Notifications of Administrative and Operational Changes	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Delegated Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
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 to provide Covered Services to Members assigned to that Health Network.
Key Personnel	Health network staff, including but not limited to, an officer, executive, administrator, director, or equivalent who has or can be assigned signature authority on behalf of the legal entity; who maintains a fiduciary duty on behalf of the legal entity; and/or who is responsible for plan administration, quality improvement, utilization management, customer service and/or provider relations.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's, or other contracted entity's, Contract with CalOptima of the Health Networks, or contracted entity's, compliance with all or a specified number of operational functional areas as determined by CalOptima.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

11. Approve Modifications to CalOptima Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network Contracted Providers to Require a Medicare Annual Wellness Visit to be Completed

Contacts

Richard Helmer, Interim Chief Medical Officer, 714-468-1100
Marie Jeannis, Executive Director, Quality & Population Health Management, 714-246-8591

Recommended Actions

1. Recommend CalOptima's Board of Directors to authorize inclusion of the Annual Wellness Visit requirement for the Primary Care Engagement and Clinical Documentation Integrity Program; and
2. Approve modifications to CalOptima Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network Contracted Providers to require a Medicare Annual Wellness Visit to be completed.

Background

In May 2020, CalOptima Board of Director's approved Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network (CCN) Contracted Providers to establish a reimbursement process to promote timely annual Primary Care Provider (PCP) visits while improving clinical documentation. Effective March 2021, a OneCare Connect (OCC) CCN contracted provider may submit a completed attestation, with supporting documentation of a member's face-to-face visit to receive a supplemental payment of $150 per member per calendar year.

Discussion

The current requirement for the CCN Primary Care Engagement and Clinical Documentation Integrity Program is any face-to-face visit and does not meet the components of the Annual Wellness Visit (AWV). An Annual Wellness Visit is a yearly appointment with a qualified provider to develop or update a personalized prevention plan to promote health and early disease detection based on a member's health risk factors. An American Association of Retired Persons study suggests that Medicare members with access to an AWV had higher utilization of preventive services/screenings and had significant reductions in hospitalization costs. In addition, an AWV supports improvements in quality measures for HealthCare Effectiveness Data and Information Set (HEDIS) reporting. More information on policy changes is in Attachment 3.

To further improve member quality of care and health outcomes, staff proposes our board approve changing the requirement, for the provider to qualify for the incentive payment, from a face-to-face to an AWV, and modification of existing CalOptima Policy CMC.2001 to align with the change.

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Fiscal Impact

The recommended action to authorize modifications to CalOptima Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network Contracted Providers, based on the anticipated start date of January 2022 has no additional impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021.

Rationale for Recommendation

CalOptima staff recommends authorizing the recommended actions to improve member access to Annual Wellness Visits, improve quality scores and quality of care for OCC members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers
2. CMC.2001: Attestation Form
3. CMC.2001: Summary of Changes

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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Policy:	CMC.2001
Title:	**Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community ~~Care~~ Network (CCN) Contracted Providers**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	05/07/2020
Revised Date:	01/01/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 2022023 BOD Review Only

I. PURPOSE

This policy describes the Primary Care Engagement and Clinical Documentation Integrity Program for Qualified Providers contracted with the CalOptima Community Network (CCN) for the OneCare Connect (OCC) Program.

II. POLICY

A. The Primary Care Engagement and Clinical Documentation Integrity Program aims to improve Member engagement with their Qualified Provider and clinical documentation accuracy and completeness in Medical Records. CalOptima's contracted CCN OCC Qualified Providers will be incentivized for reporting confirmed condition diagnosis codes and reviewing preventive care needs for each CCN OCC Member based on a timely ~~face-to-face encounter~~Annual Wellness Visit (AWV) and properly documenting such information in Medical Records~~.~~ as referenced in Title 42, Code of Federal Regulations (CFR) section 410.15.

B. Qualified Providers may earn supplemental payment after completing ~~a comprehensive annual visit~~an AWV with their assigned Member, which shall be verified by CalOptima based on the Qualified Provider's attestation and supporting Medical Records to achieve the following quality goals:

1. Improve Member engagement with their Qualified Provider measured by the percentage of CCN OCC Members who have ~~at least one (1) annual visit~~an AWV with their assigned Qualified Provider.

2. Promote health and early detection of health issues through a personalized prevention plan developed and maintained during the AWV.

~~2.~~3. Improve the accuracy and completeness of clinical documentation and the submission of condition codes measured by successful completion of ~~an~~the program's attestation form (Attachment A) by Qualified Providers.

C. For dates of service on and after ~~March~~January 1, ~~2021~~2022, a Qualified Provider is eligible for incentives, if:

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1. The Member is eligible with OCC and assigned to CCN as of the date of service (DOS);

2. The Qualified Provider ~~addresses and documents medical conditions in at least one face-to-face visit~~conducts an AWV with the Member within the Service Year;

3. The Qualified Provider ~~conducts a comprehensive assessment and~~ addresses and documents all health conditions as noted on the attestation during the ~~face-to-face visit~~AWV and as provided in Section II.B.;

4. The Qualified Provider submits the completed attestation to CalOptima with supporting Medical Records by the required deadline; and

5. The CalOptima Quality Improvement Department verifies that the potential Healthcare Effectiveness Data and Information Set (HEDIS) preventive care measures and health condition codes suggested in the attestation form (Attachment A) are documented in the supporting medical records. HEDIS specifications include both International Classification of Diseases, Tenth Edition (ICD-10) and Current Procedural Terminology (CPT) codes, which are used for hierarchical condition category (HCC) coding. HEDIS measures are quality measures designed to indicate how well preventive care is being carried out by a plan and its providers and assists CalOptima in ensuring that Members' preventive care needs are being addressed, along with their acute and chronic care needs. Accurate clinical documentation benefits both HEDIS and HCC coding. These HEDIS and health condition codes vary by Member.

D. ~~D.~~ The CalOptima Quality Improvement Department conducts oversight of the attestation accuracy and completeness of Medical Record documentation through random sample reviews and identifies an opportunity to improve clinical documentation integrity. ~~The attestation form serves as evidence of a Medicare Annual Wellness Visit (AWV).~~ As demonstrated in journal articles, Members with access to AWV are likely to complete preventive services, which will lead to improved health outcomes.

III. PROCEDURE

A. CalOptima shall conduct provider education and provide technical assistance to improve provider accuracy and completeness of clinical documentation.

B. By March of each Service Year, subject to Board approval of the continuation of the Primary Care Engagement and Clinical Documentation Integrity Program and related funding, CalOptima shall provide to each Qualified Provider via facsimile, U.S. mail or CalOptima provider portal, an attestation and Medical Records submission instruction documents for each of their assigned Members.

Upon completion of ~~a face-to-face visit~~an AWV with a Member, the Qualified Provider shall affirm, negate or provide additional information, as appropriate, regarding the individualized HEDIS preventive care measures and health conditions on the attestation document. All ~~face-to-face visits~~AWVs must be completed in the time period required by Service Year. The AWV must be completed in a face-to-face setting, including but not limited to in person and/or telehealth utilizing a real-time asynchronous audio-video platform.

C. The Qualified Provider shall submit the verified attestation form~~,~~ (Attachment A), as well as supporting Medical Records to the CalOptima Quality Improvement Department via facsimile, U.S. mail or CalOptima provider portal when available, within the Submission Period, but no later than January 31 following the Service Year.

D. The Qualified Provider must appropriately document all of the required elements in the attestation form (Attachment A), with supporting Medical Records, including, but not limited to:

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1. Member name;

2. Date of service;

3. Preventive Medicine Screening section;

4. Year-Over-Year Conditions section;

5. Suspect Conditions (Pharmacy and/or Laboratory) section;

6. Additional Conditions Present section;

7. Acceptable Qualified Provider signature with credentials; and

8. Date of authentication.

Note: For 4-6, condition diagnosis code(s) (existing and/or new) must be coded according to the *ICD-10 Clinical Modification Guidelines for Coding and Reporting*.

E. Within thirty (30) calendar days from the end of the ~~period~~ submission ~~month~~period, the CalOptima Quality Improvement Department in conjunction with Coding Initiatives shall review the program's attestation form (Attachment A) and supporting medical records to ensure each condition diagnosis code submitted by the Qualified Provider has appropriate clinical documentation. Upon receipt of Medical Records, CalOptima shall retain the Medical Records as set forth in CalOptima Policy GG.1603: Medical Records Maintenance.

F. In the event the CalOptima Quality Improvement Department, in conjunction with Coding Initiatives, determines that the attestation form (Attachment A) or supporting medical record(s) is incomplete or lacking clinical justification, CalOptima staff will deny payment and provide written notification within thirty (30) calendar days to the Qualified Provider of the determination and rationale for the rejection.

G. CalOptima will remove and not submit any condition diagnosis codes to Centers for Medicare & Medicaid Services (CMS) that are not supported in the Medical Records to protect the integrity of the process.

H. Upon receipt of CalOptima's notification of incomplete Medical Records, the Qualified Provider may dispute the findings within thirty (30) calendar days and resubmit the completed attestation form (Attachment A), with corrected medical records.

I. In the event that the CalOptima Quality Improvement Department, in conjunction with Coding Initiatives, verifies the Qualified Provider has met the conditions as specified in Sections III.D and III.E. of this Policy, CalOptima shall make a supplemental payment of $150 per completed and verified attestation form (Attachment A), with supporting Medical Records per Member per Qualified Provider per year.

1. CalOptima shall ensure per Member per Qualified Provider once a year payments are distributed to the Qualified Provider on a monthly basis.

2. CalOptima shall make supplemental payments within forty-five (45) calendar days from the end of the Submission Month.

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J. In the event CalOptima determines that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported condition diagnosis codes, CalOptima may provide additional provider education and technical assistance and/or make a referral to the Office of Compliance, as appropriate.

K. In the event CalOptima determines that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records, and such issues negatively impact quality of care or service delivered to a Member, such matters may be referred as a Potential Quality Issue in accordance with CalOptima Policy GG.1611: Potential Quality Issues Review Process or ~~refer~~referred to the Office of Compliance for further review and investigation depending on the nature and scope of the inaccurate reporting.

IV. ATTACHMENT(S)

A. ~~2020 Quality~~ Attestation Form~~-~~: 2021 Primary Care Engagement and Clinical Documentation Integrity Program

V. REFERENCE(S)

A. CalOptima Policy GG.1603: Medical Records Maintenance
B. CalOptima Policy GG.1611: Potential Quality Issues Review Process
C. CMS Medicare Managed Care Manual, IOM, Chapter 7
D. American Journal of Managed Care, "Medicare Annual Wellness Visit Association with Healthcare Quality and Costs", March 8, 2019, https://www.ajmc.com/journals/issue/2019/2019-vol25-n3/medicare-annual-wellness-visit-association-with-healthcare-quality-and-costs
E. Journal of Primary Care & Community Health, "The Effectiveness of Medicare Wellness Visits in Accessing Preventive Screening", October 08, 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5932741/
F. ~~42 CFR Section~~Title 42, Code of Federal Regulations (CFR), §§410.15 and 422.310

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/07/2020	Regular Meeting of the CalOptima Board of Directors
~~TBD~~	

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/07/2020	CMC.2001	Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers	OneCare Connect
Revised	01/01/2022	CMC.2001	Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network (CCN) Contracted Providers	OneCare Connect

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IX. GLOSSARY

Term	Definition
Annual Wellness Visit (AWV)	An Annual Wellness Visit (AWV) is a yearly visit to develop or update a personalized prevention plan to promote health and help prevent disease based on a Member's health risk factors.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Medical Record	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	~~An enrollee~~ A beneficiary ~~of~~enrolled in the CalOptima OneCare Connect program.
Potential Quality Issue (PQI)	Any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Primary Care Engagement and Clinical Documentation Integrity Program	A program to improve member engagement with their primary care provider (PCP) and clinical documentation accuracy and completeness in Qualifying Medical Records. CalOptima shall provide PCP's an attestation form (Attachment A) listing quality measures and condition diagnosis codes for each of their assigned members for clinical validation during ~~a face-to-face visit.~~ an Annual Wellness Visit (AWV). The provider shall be responsible for completing the attestation form (Attachment A)and returning the form along with supporting clinical documentation to CalOptima.
Qualified Provider(s)	For purposes of this policy, contracted Primary Care Provider (PCP), or, when applicable, other affiliated PCP, nurse practitioner or physician assistant operating within the provider group.
Service Year	January 1 through December 31 (12 months).
Submission Month	The month within the submission period in which the attestation is submitted to CalOptima.
Submission Period	January 1 of the Service Year through January 31 following the Service Year (13 months).

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Policy:	CMC.2001
Title:	**Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network (CCN) Contracted Providers**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	05/07/2020
Revised Date:	01/01/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 2022023 BOD Review Only

I. PURPOSE

This policy describes the Primary Care Engagement and Clinical Documentation Integrity Program for Qualified Providers contracted with the CalOptima Community Network (CCN) for the OneCare Connect (OCC) Program.

II. POLICY

A. The Primary Care Engagement and Clinical Documentation Integrity Program aims to improve Member engagement with their Qualified Provider and clinical documentation accuracy and completeness in Medical Records. CalOptima's contracted CCN OCC Qualified Providers will be incentivized for reporting confirmed condition diagnosis codes and reviewing preventive care needs for each CCN OCC Member based on a timely Annual Wellness Visit (AWV) and properly documenting such information in Medical Records as referenced in Title 42, Code of Federal Regulations (CFR) section 410.15.

B. Qualified Providers may earn supplemental payment after completing an AWV with their assigned Member, which shall be verified by CalOptima based on the Qualified Provider's attestation and supporting Medical Records to achieve the following quality goals:

1. Improve Member engagement with their Qualified Provider measured by the percentage of CCN OCC Members who have an AWV with their assigned Qualified Provider.

2. Promote health and early detection of health issues through a personalized prevention plan developed and maintained during the AWV.

3. Improve the accuracy and completeness of clinical documentation and the submission of condition codes measured by successful completion of the program's attestation form (Attachment A) by Qualified Providers.

C. For dates of service on and after January 1, 2022, a Qualified Provider is eligible for incentives, if:

1. The Member is eligible with OCC and assigned to CCN as of the date of service (DOS);

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2. The Qualified Provider conducts an AWV with the Member within the Service Year;

3. The Qualified Provider addresses and documents all health conditions as noted on the attestation during the AWV and as provided in Section II.B.;

4. The Qualified Provider submits the completed attestation to CalOptima with supporting Medical Records by the required deadline; and

5. The CalOptima Quality Improvement Department verifies that the potential Healthcare Effectiveness Data and Information Set (HEDIS) preventive care measures and health condition codes suggested in the attestation form (Attachment A) are documented in the supporting medical records. HEDIS specifications include both International Classification of Diseases, Tenth Edition (ICD-10) and Current Procedural Terminology (CPT) codes, which are used for hierarchical condition category (HCC) coding. HEDIS measures are quality measures designed to indicate how well preventive care is being carried out by a plan and its providers and assists CalOptima in ensuring that Members' preventive care needs are being addressed, along with their acute and chronic care needs. Accurate clinical documentation benefits both HEDIS and HCC coding. These HEDIS and health condition codes vary by Member.

D. The CalOptima Quality Improvement Department conducts oversight of the attestation accuracy and completeness of Medical Record documentation through random sample reviews and identifies an opportunity to improve clinical documentation integrity. As demonstrated in journal articles, Members with access to AWV are likely to complete preventive services, which will lead to improved health outcomes.

III. PROCEDURE

A. CalOptima shall conduct provider education and provide technical assistance to improve provider accuracy and completeness of clinical documentation.

B. By March of each Service Year, subject to Board approval of the continuation of the Primary Care Engagement and Clinical Documentation Integrity Program and related funding, CalOptima shall provide to each Qualified Provider via facsimile, U.S. mail or CalOptima provider portal, an attestation and Medical Records submission instruction documents for each of their assigned Members.

Upon completion of an AWV with a Member, the Qualified Provider shall affirm, negate or provide additional information, as appropriate, regarding the individualized HEDIS preventive care measures and health conditions on the attestation document. All AWVs must be completed in the time period required by Service Year. The AWV must be completed in a face-to-face setting, including but not limited to in person and/or telehealth utilizing a real-time asynchronous audio-video platform.

C. The Qualified Provider shall submit the verified attestation form (Attachment A), as well as supporting Medical Records to the CalOptima Quality Improvement Department via facsimile, U.S. mail or CalOptima provider portal when available, within the Submission Period, but no later than January 31 following the Service Year.

D. The Qualified Provider must appropriately document all of the required elements in the attestation form (Attachment A),with supporting Medical Records, including, but not limited to:

1. Member name;

2. Date of service;

3. Preventive Medicine Screening section;

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4. Year-Over-Year Conditions section;

5. Suspect Conditions (Pharmacy and/or Laboratory) section;

6. Additional Conditions Present section;

7. Acceptable Qualified Provider signature with credentials; and

8. Date of authentication.

Note: For 4-6, condition diagnosis code(s) (existing and/or new) must be coded according to the *ICD-10 Clinical Modification Guidelines for Coding and Reporting*.

E. Within thirty (30) calendar days from the end of the submission period, the CalOptima Quality Improvement Department in conjunction with Coding Initiatives shall review the program's attestation form (Attachment A) and supporting medical records to ensure each condition diagnosis code submitted by the Qualified Provider has appropriate clinical documentation. Upon receipt of Medical Records, CalOptima shall retain the Medical Records as set forth in CalOptima Policy GG.1603: Medical Records Maintenance.

F. In the event the CalOptima Quality Improvement Department, in conjunction with Coding Initiatives, determines that the attestation form (Attachment A) or supporting medical record(s) is incomplete or lacking clinical justification, CalOptima staff will deny payment and provide written notification within thirty (30) calendar days to the Qualified Provider of the determination and rationale for the rejection.

G. CalOptima will remove and not submit any condition diagnosis codes to Centers for Medicare & Medicaid Services (CMS) that are not supported in the Medical Records to protect the integrity of the process.

H. Upon receipt of CalOptima's notification of incomplete Medical Records, the Qualified Provider may dispute the findings within thirty (30) calendar days and resubmit the completed attestation form (Attachment A), with corrected medical records.

I. In the event that the CalOptima Quality Improvement Department, in conjunction with Coding Initiatives, verifies the Qualified Provider has met the conditions as specified in Sections III.D and III.E. of this Policy, CalOptima shall make a supplemental payment of $150 per completed and verified attestation form (Attachment A), with supporting Medical Records per Member per Qualified Provider per year.

1. CalOptima shall ensure per Member per Qualified Provider once a year payments are distributed to the Qualified Provider on a monthly basis.

2. CalOptima shall make supplemental payments within forty-five (45) calendar days from the end of the Submission Month.

J. In the event CalOptima determines that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported condition diagnosis codes, CalOptima may provide additional provider education and technical assistance and/or make a referral to the Office of Compliance, as appropriate.

K. In the event CalOptima determines that a Qualified Provider has not accurately reported condition diagnosis codes and/or does not have Medical Records, and such issues negatively impact quality of

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care or service delivered to a Member, such matters may be referred as a Potential Quality Issue in accordance with CalOptima Policy GG.1611: Potential Quality Issues Review Process or referred to the Office of Compliance for further review and investigation depending on the nature and scope of the inaccurate reporting.

IV. ATTACHMENT(S)

A. Attestation Form: 2021 Primary Care Engagement and Clinical Documentation Integrity Program

V. REFERENCE(S)

A. CalOptima Policy GG.1603: Medical Records Maintenance
B. CalOptima Policy GG.1611: Potential Quality Issues Review Process
C. CMS Medicare Managed Care Manual, IOM, Chapter 7
D. American Journal of Managed Care, "Medicare Annual Wellness Visit Association with Healthcare Quality and Costs", March 8, 2019, https://www.ajmc.com/journals/issue/2019/2019-vol25-n3/medicare-annual-wellness-visit-association-with-healthcare-quality-and-costs
E. Journal of Primary Care & Community Health, "The Effectiveness of Medicare Wellness Visits in Accessing Preventive Screening", October 08, 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5932741/
F. Title 42, Code of Federal Regulations (CFR), §§410.15 and 422.310

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/07/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/07/2020	CMC.2001	Primary Care Engagement and Clinical Documentation Integrity Program for Community Care Network Contracted Providers	OneCare Connect
Revised	01/01/2022	CMC.2001	Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network (CCN) Contracted Providers	OneCare Connect

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IX. GLOSSARY

Term	Definition
Annual Wellness Visit (AWV)	An Annual Wellness Visit (AWV) is a yearly visit to develop or update a personalized prevention plan to promote health and help prevent disease based on a Member's health risk factors.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Medical Record	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 the CalOptima OneCare Connect program.
Potential Quality Issue (PQI)	Any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Primary Care Engagement and Clinical Documentation Integrity Program	A program to improve member engagement with their primary care provider (PCP) and clinical documentation accuracy and completeness in Qualifying Medical Records. CalOptima shall provide PCP's an attestation form (Attachment A) listing quality measures and condition diagnosis codes for each of their assigned members for clinical validation during an Annual Wellness Visit (AWV). The provider shall be responsible for completing the attestation form (Attachment A)and returning the form along with supporting clinical documentation to CalOptima.
Qualified Provider(s)	For purposes of this policy, contracted Primary Care Provider (PCP), or, when applicable, other affiliated PCP, nurse practitioner or physician assistant operating within the provider group.
Service Year	January 1 through December 31 (12 months).
Submission Month	The month within the submission period in which the attestation is submitted to CalOptima.
Submission Period	January 1 of the Service Year through January 31 following the Service Year (13 months).

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2021 Primary Care Engagement and Clinical Documentation Integrity Program

Please submit completed form with supporting clinical documentation to fax # 714-571-2491.

Provider Information:	**Check box to confirm the provider completing the assessment. Enter the provider name and NPI if not populated.**
☐ Provider:	**Last, First** **505 City Parkway West Orange CA 92868**
☐ Provider:	

Patient Name:	**Last, First**		
Member ID:	**33333333T**	DOB:	**3/18/1952**
Date(s) of Service:			

Preventative Health Screening(s)

Screening to Consider	**Date Completed**	**Member Refused**	**Not Applicable**
A1c Test	_____	☐	☐
Breast Cancer Screening	_____	☐	☐
Colorectal Cancer Screening	_____	☐	☐
Diabetic Eye Exam	_____	☐	☐

Additional Comments:

_____

Year Over Year Chronic Conditions

Potential Diagnosis	**Diagnosis Code**	**Risk Factor**	**Present**	**Not Present**	**Unable to Determine**
Type 2 diabetes mellitus with hyperglycemia	E11.65	Diabetes with Chronic Complications	☐	☐	☐
Type 2 diabetes mellitus without complications	E11.9	Diabetes without Complication	☐	☐	☐
Paranoid schizophrenia	F20.0	Schizophrenia	☐	☐	☐
Delusional disorders	F22	Major Depressive, Bipolar, and Paranoid Disorders	☐	☐	☐
Schizoaffective disorder, unspecified	F25.9	Schizophrenia	☐	☐	☐
Unspecified psychosis not due to a substance or known physiological condition	F29	Reactive and Unspecified Psychosis	☐	☐	☐

Year Over Year Non-Chronic Conditions

Potential Diagnosis	**Diagnosis Code**	**Risk Factor**	**Present**	**Not Present**	**Unable to Determine**
Acute kidney failure with tubular necrosis	N17.0	Acute Renal Failure	☐	☐	☐
Acute kidney failure, unspecified	N17.9	Acute Renal Failure	☐	☐	☐

Suspect Conditions (Pharmacy and/or Laboratory)

Risk Factor	Diagnosis	Present	Not Present	Unable to Determine
Chronic Obstructive Pulmonary Disease	_____	☐	☐	☐

Other

Diagnosis	Date(s) of Service	Present
_____	_____	☐
_____	_____	☐
_____	_____	☐
_____	_____	☐
_____	_____	☐

_____ _____

Signature **Date**

OneCare Connect
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2021 Primary Care Engagement and Clinical Documentation Integrity Program

Please submit completed form with supporting clinical documentation to fax # 714-571-2491.

Provider Information:	**Check box to confirm the provider completing the assessment. Enter the provider name and NPI if not populated.**
☐ Provider:	**Last, First** **505 City Parkway West Orange CA 92868**
☐ Provider:	

Patient Name:	**Last, First**		
Member ID:	**33333333T**	DOB:	**3/18/1952**
Date(s) of Service:			

Preventative Health Screening(s)

Screening to Consider	**Date Completed**	**Member Refused**	**Not Applicable**
A1c Test	_____	☐	☐
Breast Cancer Screening	_____	☐	☐
Colorectal Cancer Screening	_____	☐	☐
Diabetic Eye Exam	_____	☐	☐

Additional Comments:

_____

Year Over Year Chronic Conditions

Potential Diagnosis	**Diagnosis Code**	**Risk Factor**	**Present**	**Not Present**	**Unable to Determine**
Type 2 diabetes mellitus with hyperglycemia	E11.65	Diabetes with Chronic Complications	☐	☐	☐
Type 2 diabetes mellitus without complications	E11.9	Diabetes without Complication	☐	☐	☐
Paranoid schizophrenia	F20.0	Schizophrenia	☐	☐	☐
Delusional disorders	F22	Major Depressive, Bipolar, and Paranoid Disorders	☐	☐	☐
Schizoaffective disorder, unspecified	F25.9	Schizophrenia	☐	☐	☐
Unspecified psychosis not due to a substance or known physiological condition	F29	Reactive and Unspecified Psychosis	☐	☐	☐

Year Over Year Non-Chronic Conditions

Potential Diagnosis	**Diagnosis Code**	**Risk Factor**	**Present**	**Not Present**	**Unable to Determine**
Acute kidney failure with tubular necrosis	N17.0	Acute Renal Failure	☐	☐	☐
Acute kidney failure, unspecified	N17.9	Acute Renal Failure	☐	☐	☐

Suspect Conditions (Pharmacy and/or Laboratory)

Risk Factor	Diagnosis	Present	Not Present	Unable to Determine
Chronic Obstructive Pulmonary Disease	_____	☐	☐	☐

Other

Diagnosis	Date(s) of Service	Present
_____	_____	☐
_____	_____	☐
_____	_____	☐
_____	_____	☐
_____	_____	☐

_____ _____

Signature **Date**

Summary of changes to Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Care Network (CCN) Contracted Providers

Below is a list of substantive changes to the policy, which are reflected in the attached reline. This list does not include non-substantive changes that may also be reflected in the redline (e.g., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Policy Pages, Section, and Line	Proposed Changes	Rationale	Impact of Change
Page 1, Title Section Page 1	Updated the policy title to: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network (CCN) Contracted Providers	Updated to reflect the accurate name of CalOptima Community Network (CCN)	No fiscal impact.
Page 1, Section II.A. Line 13	Changed from face-to-face encounter to Annual Wellness Visit (AWV)	Updated to reflect the change in process of requiring an Annual Wellness Visit (AWV) instead of a face-to-face encounter.	No fiscal impact.
Page 1, Section II.A. Lines 14-15	Added "as referenced in Title 42, Code of Federal Regulations (CFR) section 410.15."	Addition of regulation with guidelines for proper documentation.	No fiscal impact.
Page 1, Section II.B. Lines 17-18	Changed "a comprehensive annual visit" to an AWV"	Updated to reflect the change in process.	No fiscal impact
Page 1, Section II.B. 1. Line 22	Changes from at "least one (1) annual visit" to "an AWV"	Updated to reflect the change in process.	No fiscal impact
Page 1, Section II.B. 2. Lines 25-26	Added "Promote health and early detection through a personalized prevention plan developed and maintained during the AWV"	Updated to provide description of the Annual Wellness Visit (AWV) goal	No fiscal impact

Summary of changes to Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Care Network (CCN) Contracted Providers

Policy Pages, Section, and Line	Proposed Changes	Rationale	Impact of Change
Page 1, Section II.B. 2. Line 29	Change from "successful completion of attestation form" to "successful completion of the program's attestation form (Attachment A)"	Updated to clarify language and add reference to attachment.	No fiscal impact.
Page 1, Section II.C. Lines 32-33	Changed effective date from "March 1, 2021, a Qualified Provider is eligible" to "January 1, 2022, a Qualified Provider is eligible for incentives"	Updated to add program effective date of 1/1/2022 and specify that eligibility is for incentives	No fiscal impact
Page 2, Policy Section II. C. 2. Lines 3-4	Changed from "addresses and documents medical conditions in at least one face-to-face visit with the member" to "conducts and AWC with the member"	Updated to reflect the change in process.	No fiscal impact
Page 2, Section II, C. 3. Lines 6-7	Revised to: The Qualified Provider addresses and documents all health conditions as noted on the attestation during the and as provided in Section II.B.;	Updated to reflect the change in process.	No fiscal impact
Page 2, Section II.C.5. Line 15	Added reference (Attachment A) after attestation form	Added for clarity to show that Attachment A is the attestation form.	No fiscal impact
Page 2, Section II, D Lines 26-27	Deleted the following sentence. The attestation form serves as evidence of a Medicare Annual Wellness Visit (AWV).	Statement is not correct	No fiscal impact
Page 2, Section III.B. Lines 40 & 44-45	Replaced a face-to-face visit with AWV and added the following sentence: The AWC must be completed in a face-to-face setting, including but limited to in person and/or telehealth utilizing a real-time	Updated to reflect the change in process.	No fiscal impact

Summary of changes to Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Care Network (CCN) Contracted Providers

Policy Pages, Section, and Line	Proposed Changes	Rationale	Impact of Change
	asynchronous audio-video platform.		
Page 2, Section III.C. Line 47 & Section III.D. Line 53	Added reference (Attachment A) after attestation form	Added for clarity to show that Attachment A is the attestation form.	No fiscal impact
Page 3, Section III. E. Line 23 F. Line 29 I. Line 42	Changed "Quality Improvement Department" to "Quality Improvement Department in conjunction with Coding Initiatives"	To reflect current department and collaboration with other dept.	No fiscal impact
Page 4, Section IV: Attachment A: Lines 15-16	Changed title:2021 Primary Care Engagement and Clinical Documentation Integrity Program.	Provide description of Annual Wellness Visit (AWV)	No fiscal impact
Page 4, Section V. References	Revised Regulatory Reference to Title 42, Code of Federal Regulations (CFR), §§410.15 and 422.310	Clarified the correct title reference title	No fiscal impact
Page 5, Section IX. Line 2 Glossary	Updated Glossary to add Annual Wellness Visit (AWV) Definition and reference to Attachment A and removed reference to face-to-face.	Provides definition of Annual Wellness Visits.	No fiscal impact

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

12. Authorize an Amendment to the Veyo LLC Fee-for-Service Ancillary Services Contract to Increase Rates for Select Services Provided to Medi-Cal, OneCare, and OneCare Connect Members

Contact

Yunkyung Kim, Chief Operating Officer 714-246-8408

Recommended Action

Authorize the Chief Executive Officer to amend the Veyo LLC (Veyo) Fee-for-Service (FFS) Ancillary Services Contract to increase rates for select ambulatory transportation services provided to Medi-Cal, OneCare, and OneCare Connect members, effective February 1, 2022.

Background and Discussion

Staff requests approval to increase rates for Veyo, CalOptima's non-medical transportation (NMT) vendor. Staff propose to increase reimbursement rates for ambulatory service codes A0100 (Pick-up charge) and A0080 (Per-Mile fee) by 7%, effective February 1, 2022.

CalOptima has contracted with Veyo for non-medical transportation services on a FFS basis since 2018. Veyo was selected through a competitive procurement process to be CalOptima's sole NMT provider. Late last year, Veyo expressed the need to address cost pressures they have sustained on all areas of operations, including administrative, gasoline, vehicle operations, and labor. Veyo's contracted rate with CalOptima has remained constant since 2019, while the COVID-19 pandemic, among other factors, has driven up the cost of healthcare supplies and services. To date, Veyo has proven to be a regulatorily compliant and cost-effective transportation vendor.

To preserve member access to NMT services and support CalOptima's broader provider network, staff requests that the Board authorize an amendment to the Veyo ancillary services contract to increase FFS rates under that contract for Veyo.

Fiscal Impact

The recommended action to increase rates for select ambulatory services in the Veyo FFS ancillary services contract is unbudgeted. The annual net fiscal impact is approximately $1.1 million. Staff anticipates the current year net fiscal impact of approximately $452,000 will be budget neutral, as decreased utilization of transportation services will be sufficient to support the additional costs. Management will include expenses related to the updated rates in future operating budgets.

Rationale for Recommendation

Authorizing the amendment to increase Veyo's reimbursement rates for select services will preserve member access to non-medical transportation services.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Entities Covered by this Recommended Action
2. Proposed Amendment to Ancillary Services Contract
3. Previous Board Action dated November 4, 2021; "Consider Authorizing Extension of Ancillary Fee-for-Service Contracts for Non-Medical Transportation and Disposable Incontinence Supplies Providers"
4. Previous Board Action dated August 2, 2018; "Consider Authorizing Contract with a Non-Medical Transportation (NMT) Vendor Effective January 1, 2019"

Board Actions

N/A

/s/ Michael Hunn *01/27/2022*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Veyo LLC	4250 Executive Square, Suite 200	San Diego	CA	92037

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AMENDMENT 4 TO
ANCILLARY SERVICES CONTRACT

THIS AMENDMENT 4 TO THE ANCILLARY SERVICES CONTRACT ("Amendment 4") is effective as of February 1, 2022, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Veyo, LLC** ("Provider"), with respect to the following facts:

RECITALS

A. CalOptima and Provider entered an Ancillary Services Contract, by which Provider has agreed to provide or arrange for the provision of Covered Services to Members.

B CalOptima and Provider desire to amend the Contract to increase the rates payable for certain non-medical transportation services due to the unforeseen inflationary increases in underlying labor and fuel costs.

NOW, THEREFORE, the parties agree as follows:

1. ATTACHMENT C, "COMPENSATION", shall be deleted in its entirety and replaced with the attached ATTACHMENT C- Amendment 4.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment 4, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and **Veyo, LLC** have executed this Amendment 4.

FOR PROVIDER:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

DRAFT

ATTACHMENT C – AMENDMENT IV

COMPENSATION- Effective 2/1/2022

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Transportation Services Compensation

For Medi-Cal, OneCare, and OneCare Connect Members, CalOptima shall reimburse for Covered Services as follows:

A. Ambulatory Rate

Code	Provider Reimbursement	Explanation
A0100	$	Pickup Charge
A0080	$	Per-mile fee

B. Public Conveyance Service Rate

OCTA program	Provider Reimbursement	Frequency
Bus Pass **Administrative Fee Code:** A0999, to be used with invoices and encounter file Passes Code: A0110, to be used with invoice and encounter file.	• $ ___ per series issued. (Series can include Multiple or single pass) • Provider to be reimbursed at invoice cost for bus pass acquired from OCTA.	Monthly or daily passes available. Member might be eligible for multiple daily passes issued in a single transaction/series.
OC Access **Administrative Fee Code:** A0999, to be used with invoices and encounter file Pass Code: A0120, to be used with invoice and encounter file.	• $ ___ Per Series issued. (Series can include a single or multiple Vouchers) • Provider to be reimbursed at invoice cost for Vouchers acquired from OCTA.	OC Access Voucher for single use. Member might be eligible for multiple vouchers issued in a single transaction/series.

C. Private Conveyance (mileage reimbursement)

Provider Service	Provider Reimbursement	Explanation
Veyo Administrative fee code: A0999, to be used with invoice and encounter file.	$ ___ per check sent (multiple or single transactions)	Amount is payable to Veyo for each check mailed out to private driver, for reimbursement.

Private Driver reimbursement Code: S0215, to be used with invoice and encounter file.	IRS Standard Mileage Rates	Veyo to be reimbursed for the total amount paid to private driver according to the current IRS Standard Mileage Rates.

D. M&T (reimbursement)

i. M&T Coordinated, Arranged, and paid by Veyo:

Provider Service	Provider Reimbursement
• Airfare	Invoice plus $
• Meals	Invoice plus $
• Transportation (such as taxi to and from locations; exclude rental cars)	Invoice plus $
• Lodging	Invoice plus $

ii. M&T Member Reimbursement (supported by receipts):

Provider Service	Provider Reimbursement
• Airfare	Invoice plus $
• Meals	Invoice plus $
• Transportation (such as taxi to and from locations)	Invoice plus $
• Lodging	Invoice plus $
• Private Driver reimbursement	IRS Standard Mileage Rates. $__ per check sent (reimbursed to Veyo multiple or single transactions)
• Other necessary expenses – Reimbursement may be made for other necessary expenses (e.g., parking, tolls) based on actual costs supported by receipts	Invoice plus $___

II. Transportation Services Billing Requirements

1. Ambulatory claims shall be billed on a CMS 1500 claims form or may be billed electronically (EDI).

2. Public, Private Conveyance, and M&T will be billed via invoice and paid within 30 business days.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contacts
Yunkyung Kim, Chief Operating Officer (714) 246-8408
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to extend ancillary fee-for-service (FFS) contracts for Non-Medical Transportation and Disposable Incontinence Supplies Providers for a one year period through December 31, 2022.

Background and Discussion
CalOptima periodically releases RFPs to recruit providers and vendors for medical and non-medical services for its members, including Non-Medical Transportation (NMT) and Disposable Incontinence Supplies (DIS). CalOptima utilizes the ancillary contract for these providers.

Through RFPs, CalOptima selected the ancillary providers listed below for a contract term effective January 1, 2018, for a period of three years, plus two additional one-year extension options with CalOptima Board of Directors (Board) approval. The initial three-year term for the following providers is set to expire on December 31, 2021, and all are eligible for an additional one-year extension upon Board approval:

- Veyo LLC (NMT)
- Shield – California Health Care Center, Inc. (DIS)
- Medline Industries Inc. (DIS)
- Schraders' Medical Supply Inc. (DIS)
- Caremax RM Corporation (DIS)
- Byram Healthcare Centers, Inc. (DIS)

These providers are part of a broad network of provider types that CalOptima maintains to support member health needs. Through annual audits, these providers have demonstrated that they are qualified and capable of meeting the needs of CalOptima members for NMT and DIS. Prior to the expiration of the one-year extension, staff will return to the Board with recommendations for a long-term contracting strategy for DIS providers. For NMT, Staff plan to conduct an RFP in 2022 and will return to the Board with recommendations based on the results of the RFP prior to the final one-year extension. To ensure continuity of access to NMT and DIS, staff recommends Board approval to exercise the first of two one-year extension options for each of these contracts, extending them through December 31, 2022

Fiscal Impact

The recommended action to extend ancillary FFS contracts for the identified NMT and DIS providers through December 31, 2022, under the same terms and conditions, has no additional fiscal impact to the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. Management will include funding for the period of July 1, 2022, through December 31, 2022, in the CalOptima FY 2022-23 Operating Budget.

Rationale for Recommendation

Approving the extension of ancillary FFS contracts for NMT and DIS will ensure members' continued access to needed supplies and services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action August 2, 2018: Consider Authorizing Contract with a Non-Medical Transportation (NMT) Vendor Effective January 1, 2019
3. Previous Board Action December 7, 2017: Consider Authorizing Extension of Disposable Incontinence Supplies (DIS) Contracts with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers; Consider Authorizing Request for Proposal (RFP) Process

Board Actions

Board Meeting Dates	Action
December 7, 2017	Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services
August 3, 2017	Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
April 7, 2016	Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
September 3, 2015	Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic
November 6, 2014	Authorize the Chief Executive Officer to Extend Existing Disposable Incontinence Supplies Contracts for an Additional Three Years

/s/ Richard Sanchez — *10/28/2021*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Byram Healthcare Centers, Inc.	5302 Rancho Rd.	Huntington Beach	CA	92647
Caremax RM Corporation	8271 Commonwealth Ave.	Buena Park	CA	90621
Medline Industries Inc.	1960 Miro Way	Rialto	CA	92376
Schraders' Medical Supply, Inc.	5507 Brooks St.	Montclair	CA	91763
Shield – California Health Care Center, Inc	27911 W. Franklin Pkwy.	Valencia	CA	91355
Veyo LLC	4875 Eastgate Mall	San Diego	CA	92121

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Authorizing Contract with a Non-Medical Transportation (NMT) Vendor Effective January 1, 2019

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into agreement with Veyo LLC to serve as CalOptima's Non-Medical Transportation Vendor for OneCare Connect, OneCare and Medi-Cal members, except those enrolled in Kaiser. Contract to be effective January 1, 2019 for a three (3) year term with two (2) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
CalOptima has provided NMT services to Medicare beneficiaries through American Logistics Corporation (ALC) since 2008. This service was provided as a supplemental benefit to members of CalOptima's OneCare program, and upon its inception, to OneCare Connect members. On July 1, 2016, NMT benefits were extended to children accessing Early and Periodic Screening Diagnostic and Treatment (EPSDT) services through the Medi-Cal program. The contract with ALC was amended to include the additional benefit coverage.

On June 29, 2017, the California Department of Health care Services (DHCS) released All Plan Letter (APL) 17-010 providing Managed Care Plans (MCP) including CalOptima with guidance for Non-Emergency Medical Transportation and NMT services. The APL specified that, effective July 1, 2017, MCPs were expected to provide NMT services for all Medi-Cal members. These services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. NMT services may be provided by passenger car, taxi cab, or any other form of public or private conveyance as well as gas mileage reimbursement under certain conditions.

On August 3, 2017, the CalOptima Board of Directors ratified an amendment to the ALC contract to provide the expanded benefit and authorized the CEO to issue a Request for Proposal (RFP) to solicit bids from vendors to provide NMT services for CalOptima members effective April 1, 2018.

On December 7, 2017, the Board authorized staff to extend the existing ALC contract through December 31, 2018. This extension allowed staff additional time to clarify operational concerns which was essential to drafting a comprehensive Scope of Work for the RFP and to assess the RFP responses to identify the provider for this service.

Discussion
The RFP was issued by CalOptima in December 2017 and included a Scope of Work and the CalOptima contract. Three qualified vendors participated and their responses to the RFP were

reviewed by CalOptima's evaluation team, which consisted of representatives from the following departments: Customer Service, Medical Management, Contracting, Finance, Claims Administration, Regulatory Affair and Compliance, and Information Services. The selected vendor will be obligated to coordinate the NMT transportation needs of all members. As such, the RFP responders were evaluated based on services provided, ability to manage administrative services which included eligibility verification, reporting, technical capabilities, interpreter services, claims administration and adequacy of vehicles. In addition, the three vendors underwent an interview process conducted by the evaluation team and were assessed based on their presentations and qualification.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
Veyo LLC	85.91
American Logistics Company, LLC	79.09
Access2Care, LLC	71.36

The RFP evaluation team identified Veyo LLC as the vendor that best meets CalOptima's need for a safe, reliable, regulatorily compliant, technologically advanced, and cost-effective transportation vendor. Accordingly, staff recommends contracting with Veyo, LLC for an initial three (3) year term with option to extend the contract for two (2) additional one-year terms.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes approximately $7.03 million for Medi-Cal, OneCare Connect, and OneCare non-medical transportation expenses. Based on projected utilization trends, the budgeted amount is expected to be sufficient to cover the costs of providing NMT services in FY 2018-19, under the proposed reimbursement terms with Veyo, LLC. Therefore, the recommended action to enter into agreement with Veyo, effective January 1, 2019, is a budgeted item with no expected additional fiscal impact.

Rationale for Recommendation

Based on the review of the possible vendors, Staff recommends contracting with Veyo, LLC to maintain compliance with NMT requirements and to ensure members receive safe, reliable transportation to covered services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 7, 2017, Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services
    a. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic
    b. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016

c. Board Action dated August 3, 2017, Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
d. July 17, 2017 DHCS ALL Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Authorize the CEO, with the assistance of legal counsel, to amend CalOptima's contract with American Logistics for non-medical transportation (NMT) for CalOptima Medi-Cal members to extend this agreement through December 31, 2018. All other terms and conditions will remain the same.

Background/Discussion
Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract through March 31, 2018 to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed. This action was ratified by the Board at the August 3, 2017 meeting.

Also on August 3, 2017, the Board of Directors authorized staff to issue a RFP to solicit bids from vendors to provide NMT services for CalOptima Medi-Cal members with an effective date of April 1, 2018.

Staff is in the process of issuing a RFP. However, staff has determined that more time is needed to issue, assess and identify successful provider(s) to supply NMT services and to implement the services with providers. The Department of Health Care Services (DHCS) has indicated that a Dual Plan Letter will be issued to provide additional guidance regarding NMT services for Cal

MediConnect plans which has not been released yet. Additional information to address operational concerns has also been provided by DHCS, most recently on November 13, 2017. The enhanced information provided by the State has been instrumental in crafting a statement of work for the RFP. Consequentily, to allow sufficient time for the RFP process while all the updates from DHCS is being incorporated and ensure that there is no disruption to member access to this important transportation benefit, staff is requesteng Board authority to extend the American Logistics contract through December 31, 2018. It is anticipated that contract(s) with the vendor(s) selected through the RFP process will take effect on January 1, 2019.

Fiscal Impact

Because the NMT benefit was added by a DHCS APL 17-010 on June 29, 2017 and took effect the following day, funding for this mandated benefit was not included in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget. Based on draft capitation rates received from DHCS, projected costs for the NMT benefit are approximately $4.83 million for FY 2017-18. Staff anticipates that funding for NMT services will be sufficient to fully cover the costs of the benefit. Management plans to include expenses related to NMT services for the period July 1, 2018, through December 31, 2018, in the FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends extension of the current contract with American Logistics through December 2018 for NMT services to ensure that CalOptima Medi-Cal beneficiaries have access to this important benefit while the RFP process is being completed.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. Board Action dated August 3, 2017, Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit
    a. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. F. Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend current OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016 through June 30, 2016;
2. Amend budget based on Department of Health Care Services (DHCS) requirements for taxi services for qualifying Medi-Cal children and their caregiver and/or guardian per 2015 EPSDT guidelines for the 2015-2016 fiscal year;
3. Amend contracts with existing taxi services providers to include the Medi-Cal program EPSDT benefit; and
4. Issue a Request for Proposal (RFP) for taxi services for the OneCare, OneCare Connect and Medi-Cal lines of business, and authorize the CEO to contract with vendor(s) selected through this process, with contracts to be effective July 1, 2016 for a two-year term, with three additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion

Taxi transportation is a supplemental benefit for OneCare (OC) and a required benefit for OneCare Connect (OCC) members. CalOptima has contracted with American Logistics since January 1, 2008 for services to OneCare members, as a result of an RFP process was conducted in 2007. At its November 6, 2008 meeting, the Board authorized CalOptima's OC Taxi Transportation supplemental benefit, including extension of CalOptima's contract with American Logistics. At its January 2013 meeting, the Board authorized staff to leverage the OC provider network as the basis for the Duals Delivery system, and OCC was added to the current OC contract. The current contract expires December 31, 2015, based on the previous contract extensions.

Currently, the OC and OCC benefits allow for thirty (30) one-way trips per calendar year for each Member. To access this benefit, Members call American Logistics directly and schedule their taxi pick-up in order to receive one-way transportation to their appointment. This is an important benefit for dual eligible beneficiaries, for many of whom availability of transportation may determine whether they are able to obtain appropriate medical services.

The Department of Health Care Services (DHCS), through the EPSDT guidance, requires that non-medical transportation via taxi be made available to qualifying children in the Medi-Cal program. Based on projected membership and expected cost per member per month (PMPM) for Fiscal Year (FY) 2015-16, a budget of $200,000 is requested to meet this requirement, and CalOptima's current

contract with the taxi provider for OneCare and OneCare Connect are to be amended to include Medi-Cal for the qualifying EPSDT children.
As mentioned above, American Logistics has been the sole taxi provider contracted January 1, 2008 as a result of an RFQ released in 2007. In accordance with vendor management best practices, it is appropriate to complete a new RFP process, with the targeted effective date of new contract(s) of July 1, 2016.

CalOptima's Medical Management and Customer Service staff have reviewed the utilization performance of this provider, evaluated the access needs of CalOptima members, and determined that American Logistics adequately meets CalOptima's requirements for the extended contract period. The extension is requested to allow for an appropriate time frame to complete an RFP process and review all candidates. Therefore, staff recommends extending the current contract for an additional six months, through June 30, 2015.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for FY 2015-2016, the fiscal impact of the recommended action to extend the existing OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016, through June 30, 2016, is approximately $2,709,863. The recommended action is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

Based on projected membership and expected cost PMPM for qualifying Medi-Cal children enrollment for FY 2015-16, the fiscal impact of the recommended action is expected to be approximately $200,000. This is an unbudgeted item. Funding for this recommended action is expected to be available from anticipated increase in net assets in the current fiscal year.

Rationale for Recommendation
CalOptima staff recommends authorizing an extension to the contract with American Logistics for six months to ensure that OneCare and OneCare Connect members continue to have access to covered services, authorize budget and contract amendment as soon as possible for EPSDT requirement per DHCS, and issuing an RFP for a taxi services effective July 1, 2016 to ensure that members have access to taxi services prospectively.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

8/28/2015 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016

Contact
Javier Sanchez, Chief Network Officer (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with American Logistics to serve as CalOptima's Taxi Vendor for OneCare Connect, OneCare, and Medi-Cal EPSDT members effective July 1, 2016, for a two (2) year term with three (3) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current taxi services contract for CalOptima's Medicare programs has been in place since January 1, 2008. It was awarded to American Logistics through a competitive procurement process. The agreement expires on June 30, 2016.

On September 3, 2015, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for Taxi services for the contract period commencing July 1, 2016.

Following CalOptima's standard RFP process, an RFP was issued and a total of three responses were received.

Discussion
The responses to the RFP were reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracts Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All vendors were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
American Logistics	3.96
Access2Care	3.66
Veyo	3.19

Based upon the weighted scores each vendor received, American Logistics finished with the highest score at 3.96 out of a possible 5.0 of the evaluation. Access2Care finished second with a score of 3.66.

American Logistics was the only bidder who proved to have an established transportation network in the Orange County service area.

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Fiscal Impact
Under the terms of the proposed contract, consolidated taxi expenses are projected to decrease 4.9% in the next fiscal year. Management will include expenses associated with the proposed contract in the CalOptima FY 2016-17 operating budgets.

Rationale for Recommendation
CalOptima staff believes that contracting with the highest scoring taxi vendor, American Logistics, will meet the goal of continuing to ensure that CalOptima members receive safe, reliable transportation services in a cost-effective manner. CalOptima staff reviewed qualified taxi vendor responses and identified the candidate believed to best meet CalOptima's needs for safe, reliable, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with the existing taxi vendor as a result of completion of the RFP process authorized by the Board in September, 2015.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *04/01/2016*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Ratify amendment to contract with American Logistics expanding the scope of work to include the Medi-Cal covered taxi services benefit, excluding services provided for members assigned to Kaiser Permanente, for nine months beginning July 1, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend other existing contracts through no later than March 31, 2018 as necessary to ensure that qualifying Medi-Cal members have access to covered non-medical transportation services; and
3. Authorize the CEO to conduct a Request for Proposal (RFP) process to solicit bids from vendors providing non-medical transportation for CalOptima Medi-Cal, effective April 1, 2018.

Background

Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

On June 29, 2017, the California Department of Health Care Services (DHCS) released All Plan Letter (APL) 17-010 providing MCPs with guidance for NEMT and NMT. Per the APL, beginning July 1, 2017, MCPs were expected to update their NEMT policy and procedures and begin providing NMT for all Medi-Cal members. NMT services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. MCPs are required to provide NMT by passenger car, taxicab, or any other form of public or private conveyance (including private vehicle), as well as gas mileage reimbursement under certain conditions.

Transportation must be physically and geographically accessible and consistent with disability rights laws. One attendant, such as a parent, spouse or guardian may accompany the member. Additionally, a minor can travel without a parent for services which do not require parental consent and otherwise with parental consent.

Prior authorization may, at the discreation of the MCP, be required and reauthorized every 12 months when necessary. When applicable, the MCP is responsible for ensuring that parental consent is obtained in advance of arranging transportation. For NMT requests by private conveyance (e.g.,

family members, friends, neighbors, etc.), members must attest, in person, by phone, or electronically, that no other methods of transporation are reasonably available and alternatives have been reasonably exhausted. The attestation may include confirmation that the member:

- Has no valid driver's license;
- No working vehicle available in the household;
- Is unable to travel or wait for medical or dental services alone; or
- Has a physical, cognitvie, mental, or developmental limitation.

Reimbursement for private conveyance includes only mileage at the Internal Revenue Service (IRS) standard mileage rates for medical purposes (the 2017 reimbursement rate is $0.17 per mile) and can be made only for drivers compliant with California driving requirements, which includes a valid driver's license, vehicle registration and vehicle insurance. Neither the legislation nor the APL establish any additional specific requirements or criteria for driver eligibility.

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract on a short term basis to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed.

Discussion

CalOptima staff leveraged an existing transportation contract to ensure that the effective date for the new NMT requirement was met. On July 1, 2017, CalOptima began providing the expanded NMT services including the amended contract with American Logistics, as well as via taxi, bus, and private conveyance arranged by members. This benefit is separate from other existing transportation benefits, and members can continue to access emergency and NEMT services in accordance with existing processes. To access NMT services, members can contact CalOptima's Customer Service Department to discuss and coordinate transportation.

Should all other reasonable transportation options be exhausted and private conveyance be required, CalOptima's Customer Service Department will issue a reference number, and members can arrange for their own transportation, with their private drivers submitting gas mileage receipts for reimbursement to CalOptima. In order to receive reimbursement, private drivers will also be required to submit proof that they meet California driving requirements which include valid driver's license, vehicle registration, and evidence of vehicle insurance.

In order to ensure that qualifying Medi-Cal members have access to public conveyance options, bus and taxi services are being offered. CalOptima will continue to procure passes from the Orange County Transit Authority (OCTA) for both bus and OC ACCESS, for members who are unable to use regular bus service due to functional limitations caused by a disability. For taxi services, the

scope of work of the current contract with American Logistics (CalOptima's contracted provider for OneCare and OneCare Connect) has been amended through March 31, 2018 as a short term measure to ensure that this transportation benefit is available to Medi-Cal members.

During this nine month period, CalOptima staff will consider longer term options for providing the NMT benefit and conduct an RFP to identify potential vendors and return to the Board with the RFP results and recommendations. In addition, staff is in the process of developing a comprehensive transportation program, and will be returning to the Board with recommendations and policy updates.

Fiscal Impact

The recommended action to ratify the amendment to the American Logistics contract, amend contracts with existing providers, and conduct an RFP process is expected to result in an increase in both claims and administration expense for CalOptima. However, because non-medical transportation is a newly-mandated benefit and since no projected utilization data has been provided by DHCS, the fiscal impact of this benefit is not currently known. CalOptima staff will continue to work with DHCS to ensure that funding for non-medical transportation will be appropriate and sufficient to fully cover the costs of the benefit. On a prospective basis, staff will update the Board as appropriate on the expenses associated with providing this benefit. Long term, staff anticipates that the program will be budget neutral to CalOptima.

Rationale for Recommendation

CalOptima staff recommends the above actions in order to be compliant with the NMT requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *7/27/2017*

Authorized Signature — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES

PURPOSE:
This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. With the passage of Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), the Department of Health Care Services (DHCS) is clarifying MCPs' obligations to provide and coordinate NEMT and NMT services. In addition, this APL provides guidance on the application of NEMT and NMT services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F)[1]. *Revised text is found in italics.*

BACKGROUND:
DHCS administers the Medi-Cal Program, which provides comprehensive health care services to millions of low-income families and individuals through contracts with MCPs. Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, MCPs are required to establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services. NEMT services are authorized under SSA Section 1902 (a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2.

AB 2394 amended WIC Section 14132(ad)(1) to provide that, effective July 1, 2017, NMT is covered, subject to utilization controls and permissible time and distance standards, for MCP members to obtain covered Medi-Cal medical, dental, mental health, and substance use disorder services. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services and must make their best effort to refer for and coordinate NMT for all Medi-Cal services

[1] CMS-2333-F

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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not covered under the MCP contract. Effective October 1, 2017, in part to comply with CMS-2333-F and to have a uniform delivery system, MCPs must also provide NMT for Medi-Cal services that are not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system.

REQUIREMENTS:

Non-Emergency Medical Transportation
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250[2].

MCPs must ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS[3]. MCPs are also required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs. For Medi-Cal services that are not covered by the MCP's contract, the MCP must make its best effort to refer for and coordinate NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has prior authorization.

MCPs are required to provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services[4]. MCPs are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches[5]. MCPs shall also ensure door-to-door assistance for all members receiving NEMT services.

Unless otherwise provided by law, MCPs must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT for a minor who is unaccompanied by a parent or a guardian.

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[2] 22 CCR Section 51323 (b)(2)(C)
[3] Exhibit A, Attachment 1 (Organization and Administration of the Plan)
[4] 22 CCR Section 51323 (a)
[5] Manual of Criteria for Medi-Cal Authorization, Chapter 12.1 Criteria for Medical Transportation and Related Services

MCPs must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

MCPs must provide the following four available modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual[6] and the CCR[7] when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:

1. MCPs must provide **NEMT ambulance services** for[8]:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    - Transfers from an acute care facility to another acute care facility.
    - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    - Transport for members with chronic conditions who require oxygen if monitoring is required.

2. MCPs must provide **litter van services** when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport[9].
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[10].

3. MCPs must provide **wheelchair van services** when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport[11].

[6] Medi-Cal Provider Manual: Medical Transportation – Ground
[7] 22 CCR Section 51323(a) and (c)
[8] Medi-Cal Provider Manual: Medical Transportation – Ground, page 9, Ambulance: Qualified Recipients
[9] 22 CCR Section 51323 (2)(A)(1)
[10] 22 CCR Section 51323 (2)(B)
[11] 22 CCR Section 51323 (3)(A)

- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation[12].
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[13].

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below)[14]:

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring.

4. MCPs must provide **NEMT by air** only under the following conditions[15]:
   - When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms

MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate *without* assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

[12] 22 CCR Section 51323 (3)(B)
[13] 22 CCR Section 51323 (3)(C)
[14] Medi-Cal Provider Manual: Medical Transportation – Ground, page 11, Wheelchair Van
[15] 22 CCR Section 51323 (c)(2)

- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested.

Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the MCP.

Non-Medical Transportation
NMT has been a covered benefit when provided as an EPSDT service[16]. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services. For all Medi-Cal services not covered under the MCP contract, MCPs must make their best effort to refer for and coordinate NMT.

Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member's needs.

MCPs are contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT transportation services[17]. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available.

At a minimum, MCPs must provide the following NMT services[18]:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle)[19], as well as mileage reimbursement for medical purposes[20] when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

[16] WIC 14132 (ad)(7)
[17] Exhibit A, Attachment 13 (Member Services), Written Member Information
[18] WIC Section 14132(ad)
[19] Vehicle Code (VEH) Section 465
[20] IRS Standard Mileage Rate for Business and Medical Purposes

- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics and other equipment.
- MCPs must provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- MCP may use prior authorization processes for approving NMT services and re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license.
    - Has no working vehicle available in the household.
    - Is unable to travel or wait for medical or dental services alone.
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements

The MCPs must authorize the use of private conveyance (private vehicle)[21] when no other methods of transportation are reasonably available to the member or provided by the MCP. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available. The attestation can be made over the

[21] VEH Section 465

phone, electronically, or in person. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include[22]:

- Valid driver's license.
- Valid vehicle registration.
- Valid vehicle insurance.

MCPs are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation[23].

Non-Medical Transportation Authorization

MCPs may authorize NMT for each member prior to the member using NMT services. If the MCP requires prior authorization for NMT services, the MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The MCP's prior authorization process must be consistently applied to medical/surgical, mental health and substance use disorder services as required by CMS-2333-F.

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards

MCPs are contractually required to meet timely access standards[24]. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs and Dual Plan Letters. MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

[22] VEH Section 12500, 4000, and 16020
[23] IRS Standard Mileage Rate for Business and Medical Purposes
[24] 28 CCR Section1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)

If you have any questions regarding this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension of Disposable Incontinence Supplies (DIS) Contracts with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers; Consider Authorizing Request for Proposal (RFP) Process

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend the existing Disposable Incontinence Supplies (DIS) contracts expiring December 31, 2017, with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers for a one (1) year period; and
2. Authorize the CEO to complete a Request for Proposal (RFP) process for DIS and to select and contract with vendor(s) selected via the RFP process effective January 1, 2019.

Background

Disposable Incontinence Supplies (subject to utilization controls) are covered benefits under the Medi-Cal program and are CalOptima's financial responsibility for CalOptima Direct (COD) members. These supplies include, but are not limited to, disposable diapers and briefs, liners and underpads. The three current providers were contracted through the competitive procurement process in 2009, and the contracts took effect on January 1, 2010. The contracts with extension options, expired on December 31, 2014. Board action taken November 6, 2014 extended the contracts for three additional years through December 31, 2017. Upon review of the performance of the existing vendors, staff has determined that the existing providers are sufficient to meet the current needs of CalOptima members and will continue to be sufficient for the next year.

Due to the time that has elapsed since the last RFP for DIS in 2009, staff recommends that a new RFP be issued for DIS. Therefore, management recommends that the Board authorize extension of the current DIS contracts for a one-year period under the same terms and conditions while staff conducts a competitive procurement process for DIS.

The renewal of the contracts with existing providers will support the stability of CalOptima's contracted provider network and ensure consistent delivery of disposable incontinence supplies. Contract language does not guarantee any provider any particular volume or exclusivity, and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, included approximately $3.9M in expenses related to incontinence supplies. Since rates and terms of the existing contracts for incontinence supplies will remain unchanged through the extension period,

the recommended action to extend current contracts with incontinence supply providers from January 1, 2018, through June 30, 2018, is a budgeted item with no additional fiscal impact. Management will include expenses related to incontinence supplies for the period July 1, 2018, through December 31, 2018, in the FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends authorizing the extension of existing contracts with Disposable Incontinence Supplies providers to maintain the current effective provider network and meet member needs while an RFP process is being conducted.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated November 6, 2014, Authorize the Chief Executive Officer to Extend Existing Disposable Incontinence Supplies Contracts for an Additional Three Years

/s/ Michael Schrader — **Authorized Signature**

11/30/2017 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 6, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VI. D. Authorize the Chief Executive Officer (CEO) to Extend Existing Disposable Incontinence Supplies Contracts for an Additional Three Years

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Action

Authorize the CEO to extend existing disposable incontinence supplies contracts expiring December 31, 2014, for an additional 3-year period ending December 31, 2017.

Background/Discussion

Disposable incontinence supplies are a covered benefit under the Medi-Cal program and are CalOptima's financial responsibility for CalOptima Direct (COD) members. These supplies include disposable diapers and briefs, liners and underpads, and related items. The three current providers of these supplies to CalOptima members were awarded contracts based on a competitive procurement process in 2009, and the contracts took effect on January 1, 2010. These contracts, including all extension options, expire December 31, 2014.

Upon review of the performance of the existing vendors, staff determined that the existing providers are sufficient to meet the current needs of CalOptima members. Therefore, management recommends that the Board authorize extension of the current disposable incontinence supplies contracts for a three-year period under the same terms and conditions.

The renewal of the contracts with existing providers will support the stability of CalOptima's contracted provider network and ensure consistent delivery of disposable incontinence supplies. The Board of Directors will continue to preside over contract directives and renewals. Contract language does not guarantee any provider any particular volume or exclusivity, and allows for CalOptima and the providers to terminate the contracts with or without cause.

Fiscal Impact

The recommended action is budget neutral, with no material fiscal impact anticipated to CalOptima.

Rationale for Recommendation

CalOptima staff recommends authorizing the extension of existing contracts with disposable incontinence supplies providers to maintain the current effective provider network and meet member needs.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader *10/31/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Authorizing Contract with a Non-Medical Transportation (NMT) Vendor Effective January 1, 2019

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into agreement with Veyo LLC to serve as CalOptima's Non-Medical Transportation Vendor for OneCare Connect, OneCare and Medi-Cal members, except those enrolled in Kaiser. Contract to be effective January 1, 2019 for a three (3) year term with two (2) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
CalOptima has provided NMT services to Medicare beneficiaries through American Logistics Corporation (ALC) since 2008. This service was provided as a supplemental benefit to members of CalOptima's OneCare program, and upon its inception, to OneCare Connect members. On July 1, 2016, NMT benefits were extended to children accessing Early and Periodic Screening Diagnostic and Treatment (EPSDT) services through the Medi-Cal program. The contract with ALC was amended to include the additional benefit coverage.

On June 29, 2017, the California Department of Health care Services (DHCS) released All Plan Letter (APL) 17-010 providing Managed Care Plans (MCP) including CalOptima with guidance for Non-Emergency Medical Transportation and NMT services. The APL specified that, effective July 1, 2017, MCPs were expected to provide NMT services for all Medi-Cal members. These services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. NMT services may be provided by passenger car, taxi cab, or any other form of public or private conveyance as well as gas mileage reimbursement under certain conditions.

On August 3, 2017, the CalOptima Board of Directors ratified an amendment to the ALC contract to provide the expanded benefit and authorized the CEO to issue a Request for Proposal (RFP) to solicit bids from vendors to provide NMT services for CalOptima members effective April 1, 2018.

On December 7, 2017, the Board authorized staff to extend the existing ALC contract through December 31, 2018. This extension allowed staff additional time to clarify operational concerns which was essential to drafting a comprehensive Scope of Work for the RFP and to assess the RFP responses to identify the provider for this service.

Discussion
The RFP was issued by CalOptima in December 2017 and included a Scope of Work and the CalOptima contract. Three qualified vendors participated and their responses to the RFP were

reviewed by CalOptima's evaluation team, which consisted of representatives from the following departments: Customer Service, Medical Management, Contracting, Finance, Claims Administration, Regulatory Affair and Compliance, and Information Services. The selected vendor will be obligated to coordinate the NMT transportation needs of all members. As such, the RFP responders were evaluated based on services provided, ability to manage administrative services which included eligibility verification, reporting, technical capabilities, interpreter services, claims administration and adequacy of vehicles. In addition, the three vendors underwent an interview process conducted by the evaluation team and were assessed based on their presentations and qualification.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
Veyo LLC	85.91
American Logistics Company, LLC	79.09
Access2Care, LLC	71.36

The RFP evaluation team identified Veyo LLC as the vendor that best meets CalOptima's need for a safe, reliable, regulatorily compliant, technologically advanced, and cost-effective transportation vendor. Accordingly, staff recommends contracting with Veyo, LLC for an initial three (3) year term with option to extend the contract for two (2) additional one-year terms.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, includes approximately $7.03 million for Medi-Cal, OneCare Connect, and OneCare non-medical transportation expenses. Based on projected utilization trends, the budgeted amount is expected to be sufficient to cover the costs of providing NMT services in FY 2018-19, under the proposed reimbursement terms with Veyo, LLC. Therefore, the recommended action to enter into agreement with Veyo, effective January 1, 2019, is a budgeted item with no expected additional fiscal impact.

Rationale for Recommendation

Based on the review of the possible vendors, Staff recommends contracting with Veyo, LLC to maintain compliance with NMT requirements and to ensure members receive safe, reliable transportation to covered services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

13. Authorize Allocation of Intergovernmental Transfer (IGT) 10 Funds to the Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP)

Contacts

Richard Helmer, Chief Medical Officer (Interim), 714-468-1100
Marie Jeannis, Executive Director, Quality and Population Health Management, 714-246-8591

Recommended Action

Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in an amount not to exceed $421,200 for staffing resources for the COVID-19 Member VIP.

Background

In 2021, the CalOptima Board of Directors approved CalOptima's COVID-19 Member VIP. The goal of this program was to motivate members to get the required doses of COVID-19 vaccines by providing $25 non-monetary gift card per vaccine and booster. Additionally, on March 4, 2021, the Board approved the use of Intergovernmental Transfer (IGT) 10 funds for two temporary staff in support of administrative assistance for the COVID VIP Program. Although CalOptima has made significant strides in vaccination, the COVID-19 pandemic continues to impact the well-being of our members.

In 2021, CalOptima membership grew from 800,000 to over 860,000. Additionally, the number of CalOptima members eligible for the COVID-19 vaccine increased, from 408,000 to over 810,000, as a result of the Food and Drug Administration approving vaccines for members 5 – 11 years of age and boosters for all individuals 16 years and older. Eligible members can receive up to three $25 non-monetary gift cards (one gift card per dose and one for the booster). Depending on the vaccine dose requirement and member participation, CalOptima may potentially distribute over 1.6 million gift cards.

As of January 14, 2022, CalOptima has distributed more than 578,000 gift cards to eligible members with the assistance of our fulfilment vendor. CalOptima's contracted fulfillment vendor is responsible for mailing gift cards to the largest Medi-Cal threshold language populations (i.e., English, Spanish, and Vietnamese). Of the 578,000 gift cards distributed, Population Health Management (PHM) staff has manually processed over 114,000 mailings to the smaller threshold language populations as well as processing returned mail. The volume of return mail averages 1,500 per month. Staff are also responsible for data entry, tracking and responding to member inquiries. Additionally due to the increase in gift card processing volumes, the ongoing pandemic and additional vaccine booster doses, the PHM Department call center has experienced a significant increase in incoming calls (see Attachment 4). As the number of members eligible for vaccines continues to grow, management anticipates that the volume of calls and returned mail will continue to increase.

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Discussion

To ensure timely and accurate processing for the COVID-19 Member VIP, staff recommends that the Board allocate additional funding for temporary staffing, not to exceed $421,200, for calendar year (CY) 2022 through the end of the first quarter of CY 2023.

CalOptima staff proposes to allocate staffing resources through the utilization of Intergovernmental Transfer (IGT) 10 funds. CalOptima's share of IGT 10 funds is $63.57 million ($45.15 million was received in May 2021 and $18.42 million was received in December 2021). As of December 20, 2021, the CalOptima Board of Directors has allocated $36.48 million of IGT 10 funds, leaving $27.09 million unallocated. More information on IGT 10 is in Attachment 5.

Fiscal Impact

The recommended action to allocate up to $421,200 in IGT 10 funds for staffing resources for the COVID-19 Member VIP has no net fiscal impact to CalOptima's Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021. Expenditure of IGT funds is for covered Medi-Cal services provided to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Authorization of the expenditures will allow CalOptima to process and assist members with their COVID-19 Member VIP questions and concerns in a timely manner. The recommended action will support CalOptima's efforts to help achieve community immunity and continue providing access to quality health care for members during the ongoing pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Previous Board Action January 7, 2021, "Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021"
2. Previous Board Action March 4, 2021, "Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program"
3. Previous Board Action December 20, 2021, "Consider Recommending that the Board of Directors Authorize Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022"
4. Population Health Management Weekly Incoming Call Volume Analysis 2020-2021 & Customer Service Incoming Call Volumes
5. Intergovernmental Transfers (IGT) 10 Summary

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
January 7, 2021	Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021	CY 2021	$35,000,000
March 4, 2021	Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program	CY 2021	$1,179,619
December 20, 2021	Consider Recommending that the Board of Directors Authorize Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022	CY 2022	The original funding level of $35 million

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, 714-246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8574
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Actions

1. Authorize the development and implementation of a COVID-19 Vaccination Incentive Program (VIP) for Calendar Year (CY) 2021, as described below, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to DHCS approval prior to implementation;
2. Approve the recommended allocation of Intergovernmental Transfer (IGT) 10 funds, not to exceed $20 million, to provide two $25 nonmonetary gift cards to individual Medi-Cal members age 14 and older for receiving the two required doses of the COVID-19 vaccine (one gift card per shot); and
3. Authorize implementation of the VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.
4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an Memorandum of Understanding (MOU), and/or contract or contract amendment with the Orange County Health Care Agency (OCHCA) as appropriate for administration and implementation of the VIP.

Background

In late December 2020, the first doses of the COVID-19 vaccines arrived in Orange County. Vaccines will be distributed according to a phased approach, with high-priority groups vaccinated first and eventually the general public as determined by the California Department of Public Health and local health department. The U.S. Food and Drug Administration issued an emergency use authorization (EUA) for the Pfizer-BioNTech and Moderna vaccines, both of which offer more than 94% protection against COVID-19 when two doses are taken. Public health experts recommend that at least 70% of the population needs to get vaccinated to develop herd community, which can bring an end to the pandemic.

As the only Medi-Cal plan serving Orange County's most vulnerable residents, CalOptima is responding in collaboration with the Orange County Health Care Agency (OCHCA) to support the community in achieving herd immunity. The first step is a strategy that promotes COVID-19 vaccination, including tailoring member education on the importance of vaccination, dispelling misconceptions, and providing nonmonetary member incentives to ensure health equity across race, ethnicity and socioeconomic status. To support this effort, CalOptima staff is seeking an allocation of IGT 10 funds.

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been

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received, and IGT 10 funds will be distributed in two separate installments, which are expected from the state in 2021.

Discussion

Subject to state approval, staff will work with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The proposed program includes:

1. A mailing to all members with information about the vaccine.
2. A targeted text messaging campaign. When different priority groups are permitted to be vaccinated, CalOptima will send out targeted text messages to these members letting them know the following:
    a. They are now eligible to be vaccinated.
    b. Where they need to go to be vaccinated. (This information is not yet available, but staff continue to work with OCHCA to establish vaccine events in targeted geographic locations within the county. The vaccine events are likely to begin in Spring 2021, but may extend into the fall, depending on the vaccine distribution timeline as established by OCHCA.)
3. A targeted phone call campaign to population segments who are at high risk for not getting vaccinated. This will begin once the vaccine is widely available to at least essential workers, according to the phased approach.

Staff projects that as many as 400,000 members will participate in this program. To encourage members to participate in vaccination, staff proposes to provide two $25 nonmonetary gift cards for Medi-Cal members age 14 and older for receiving each of two doses of the COVID-19 vaccine, for a total of $50. Members will be encouraged to sign up with the OCHCA's app, Othena, at no cost, to receive the gift card incentives, one gift card for each shot received. The app is being developed to help healthcare providers track vaccine recipients to ensure they get a booster shot and to monitor for side effects. Staff is also seeking authority to enter into a Memorandum of Understanding (MOU) and/or contract or contract amendment with the County as necessary to implement the program. If it is subsequently determined that agreements with other entities, organizations or vendors are necessary, staff will return to the Board with further recommendations for consideration at a later date.

The targeted timeframe for the COVID-19 nonmonetary incentive is CY 2021. IGT 10 funds have not yet been received. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021).

Due to timing issues, staff requests that the Board authorize the CEO to implement the COVID-19 Vaccination Incentive Program for CY 2021 prior to CalOptima's receipt of IGT 10 funds from DHCS. Providing the nonmonetary incentive to coincide with the availability of the COVID-19 vaccination to members will support CalOptima's health promotion efforts in our community.

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It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's administrative loss ratio (ALR), rather than the medical loss ratio (MLR).

Fiscal Impact

The recommended action to allocate up to $20 million in IGT 10 funds to support the COVID-19 Vaccination Member Incentive Program has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended to implement the program will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends adding a COVID-19 vaccination member incentive component to CalOptima's preventive initiatives to educate and encourage member participation. The recommended actions will support CalOptima's efforts to help the community reach herd immunity, address health disparities, and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. CalOptima Board Action dated February 6, 2020, Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

/s/ Richard Sanchez *12/31/2020*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

16 Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Actions

1. Ratify and authorize the unbudgeted expenditures in an amount up to $262,500 from existing reserves for mailing member education materials related to the Coronavirus (COVID-19) vaccination;
2. Authorize unbudgeted expenditures in an amount up to $695,974 from existing reserves for the COVID-19 Member Vaccination Incentive Program (VIP) to include the OneCare and OneCare Connect populations, subject to regulator(s) approval, as necessary;
3. Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in an amount not to exceed $221,145 for staffing resources for the COVID-19 Member VIP; and
4. Authorize funding for staffing resources for the COVID-19 Member VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.

Background

On January 7, 2021, the CalOptima Board of Directors (Board) approved a COVID-19 Member VIP for calendar year 2021 (see Attachment 1). The goal of this program is to motivate members to get the required doses of COVID-19 vaccination by providing nonmonetary gift cards.

In addition to offering nonmonetary incentives, another essential strategy to promote vaccination is tailoring member education on the importance of vaccination and correcting misconceptions. As discussed at the Board's January 7, 2021 meeting, one element of the member communication plan is to mail information about the vaccine to all members. To provide this information in a timely manner, in February 2021, CalOptima has mailed member educational pieces (e.g., a cover letter addressing the importance of receiving vaccines, information on incentive administration, frequently asked questions, etc.) to all members. In addition, the texting campaign, which is another element of the strategy for member outreach, is currently pending approval by the Department of Health Care Services (DHCS), and staff will seek any additional required approvals as appropriate.

Staff also note that the OneCare (OC) and OneCare Connect (OCC) populations, among CalOptima's most vulnerable populations, were initially excluded from the COVID-19 Member VIP as this initiative is funded by IGT 10 dollars. In order to ensure the safety of these vulnerable populations and promote vaccination, staff recommend that the Board allocate additional funding for outreach and education of the OC and OCC members to align CalOptima's efforts with the County of Orange's COVID-19 Vaccine Equity Pilot Program (VEPP) deployment.

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Discussion

Member Education Mailing

Staff have been working with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The program includes a mailing to all members with information about the vaccine. Mailing outreach allows members who do not have a mobile phone or access to internet services to receive CalOptima's COVID-19 Member VIP information and other important vaccine-related information.

Staff estimates that the total cost for mailing educational materials, including postage, envelop, and printing and fulfillment, is $250,000. In addition, staff estimates mailing approximately 5,000 to 5,500 gift cards each month from March through June 2021. The total estimated cost for gift card mailing is $12,500.

Expanding the COVID-19 Member VIP to OC and OCC

OC and OCC members are among the highest risk populations that CalOptima serves due to their age and underlying chronic conditions. The OC/OCC populations are not eligible for IGT dollars as Medicare is their primary health insurance coverage; therefore, they were excluded from the COVID-19 Member VIP request that was approved at the Board's January 7, 2021 meeting. In order to promote vaccination among these populations, staff recommends that the Board authorize unbudgeted expenditures to expand the COVID-19 Member VIP to include OC and OCC members, subject to regulator(s) approvals as necessary.

Staff estimates a 70% vaccine take-up rate by OC and OCC members. The total estimated cost for Medicare member incentive gift cards and related gift card activation fees is $64,000 for OC and $631,974 for OCC. Staff note that OC and OCC members residing in long-term care settings and PACE members are excluded from this COVID-19 Member VIP.

Staffing Resources for COVID-19 Member VIP

In order to deploy the COVID-19 Member VIP in a timely and effective manner, staff recommends hiring a dedicated Program Specialist, Int. and two temporary staff under the Population Health Management department. The Program Specialist, Int. will work with various internal and external stakeholders to execute the planned activities, track vaccination status and member incentive distribution status. Staff proposes making this position permanent beyond the pandemic as member incentive programs continue to grow, and permanent staff resources would be beneficial to support coordination and tracking of various member incentives. Temporary staff will support any administrative and data entry related responsibilities.

The estimated salary and benefit expenses for the Program Specialist, Int. is $147,225 for an 18 month period. The estimated cost for 2 temporary staff for a 9 month period or approximately 1,000 work hours is $73,920.

CalOptima staff proposes staffing resources for COVID-19 Member VIP for up to $221,145 through allocation of IGT 10 funds. It is anticipated that CalOptima's share of IGT 10 funds will be

approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021). Due to timing issues, staff requests the Board to authorize the CEO to approve this staff resources request prior to CalOptima's receipt of the IGT 10 funds from DHCS. As of February 1, 2021, the CalOptima Board of Directors has allocated $36.2 million of the anticipated IGT 10 funds, leaving $29.8 million unallocated. IGT 10 funds allocation recommendation requests totaling $221,145, including this one, are being made today. More information on IGT 10 is attached.

Fiscal Impact

The recommended actions to ratify and authorize mailing member education materials related to the COVID-19 vaccination and to include the OC and OCC populations in the COVID-19 Member VIP are unbudgeted items. An allocation of up to $958,474 from existing reserves will fund these actions.

The recommended action to allocate up to $221,145 for staffing resources for the COVID-19 Member VIP has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended for this purpose will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted, one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to promote vaccination for all members regardless of their eligibility program. The recommended actions will support CalOptima's efforts to help the community reach herd immunity and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated January 7, 2021, Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021
2. Intergovernmental Transfers (IGT) 10 Summary

/s/ Richard Sanchez — *02/24/2021*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Consent Calendar

15. Consider Authorizing an Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022

Contacts

Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Actions

1. Recommend Extending CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program through Calendar Year 2022 (CY 2022), and authorize the provision of vaccine incentives for Members who receive booster or additional doses of the COVID-19 vaccine; and
2. Authorize use of the previously approved allocation of unspent IGT 10 funds, not to exceed the original funding level of $35 million, to include provision of a $25 non-monetary gift card (one gift card per shot) to individual Medi-Cal members who receive a booster or additional dose of the COVID-19 vaccine.

Background

On January 7, 2021, the CalOptima Board of Directors allocated $35 million in Intergovernmental Transfer (IGT) 10 funds for CalOptima's COVID-19 VIP (CalOptima VIP). Staff notes that the originally recommended request was $20 million; however, during the Board meeting, the Board increased the allocation to $35 million and approved an amended motion to include incentives for all CalOptima Medi-Cal members, subject to DHCS approval, for receiving the two doses of the COVID-19 vaccine, including children under 14 years of age. The program included Member Health Rewards for eligible CalOptima members to receive a $25 gift card per vaccine for a maximum of $50 per individual CalOptima Member. On the same day, the Board also approved $400,000, from the Homeless Health Initiative, to provide Member Health Rewards for members experiencing homelessness.

On March 4, 2021, the Board approved $695,974 from existing reserves to support OneCare and OneCare Connect Member Health Rewards, $262,500 from existing reserves for member education materials and $221,145 from IGT 10 funds for staffing resources.

On August 13, 2021, DHCS released APL 21-010: Medi-Cal COVID-19 VIP (DHCS VIP), to improve Medi-Cal members' vaccination rates across the state of California. DHCS allocated up to $350 million statewide to incentivize COVID-19 vaccination efforts for the period September 1, 2021, through February 28, 2022. As presented at the August Board meeting, a combined total of $250 million can be earned by health plans, including CalOptima, for activities designed to close the vaccination gaps for enrolled Medi-Cal members. The APL included $100 million, to be used by all health plans, for direct member incentives of $50, at maximum, per eligible enrollee. The DHCS VIP includes all unvaccinated CalOptima members, 12 years and older and has also identified populations of focus such as:

- Members who are homebound and unable to travel to vaccination sites
- Members between the ages of 50 and 64 with multiple chronic diseases

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- Members who self-identify as persons of color, and younger members between the ages of 12 and 25.

CalOptima joined the DHCS VIP in September 2021 to increase the rates of vaccinated members. The Food & Drug Administration (FDA) has continued to authorize the COVID-19 vaccine for additional uses and populations after the implementation of the DHCS VIP, such as:

- Pfizer Booster was approved on September 22, 2021;
- Moderna and Johnson & Johnson Boosters were approved on October 20, 2021;
- Vaccine for children 5 – 11 years of age was approved on October 29, 2021.

As such, these populations are not covered under the DHCS VIP for member health rewards. To help ensure that all CalOptima members are fully vaccinated, staff proposes extending the CalOptima VIP through CY 2022 and using the remaining IGT funds to continue providing $25 non-monetary gift cards for Medi-Cal members receiving the two required doses of the COVID-19 vaccine (one gift card per shot) and receiving a single COVID-19 booster shot.

Discussion

To date, with the state's support and collaboration with various community organizations, CalOptima has achieved significant progress in vaccinating its members in CY 2021. As of November 5, 2021:

- 430,950 members, eligible for the vaccine, have been vaccinated;
- 417,857 of vaccinated members are eligible for non-monetary gift cards (371,178 gift cards have been fulfilled [~89%]);
- 65% of members aged 16 years and older received at least one dose of vaccine
- 63% of members aged 12 years and older received at least one dose of vaccine

Although CalOptima has made significant strides in vaccination, staff believes that we must continue outreaching to the community and increase vaccination rates until herd immunity is reached. The targeted timeframe for the approved CalOptima VIP was for CY 2021 (January 1, 2021 – December 31, 2021). Therefore, staff recommends extending the CalOptima VIP through CY 2022, continuing to provide $25 non-monetary gift cards for Medi-Cal members receiving the two required doses of the COVID-19 vaccine, and providing $25 nonmonetary gift cards for Medi-Cal members receiving the single booster shot.

Staff believes these recommended actions will help ensure community safety amid the ongoing COVID-19 pandemic.

Fiscal Impact

The recommended action to authorize the revision to and extension of the CalOptima Member VIP through December 31, 2022, has no net fiscal impact to CalOptima Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021.

As of October 18, 2021, approximately $15.6 million of the $35 million Board allocation has been spent. Staff anticipates the remaining $19.4 million in IGT 10 funds will be sufficient to cover program expenses through December 31, 2022. Expenditure of these IGT funds is for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff believes that non-monetary gift cards are great tools to motivate members to protect themselves from COVID-19 and increase member participation. The recommended actions will support CalOptima's efforts to continue reaching herd immunity and address health disparities during the COVID-19 public health crisis.

Concurrence

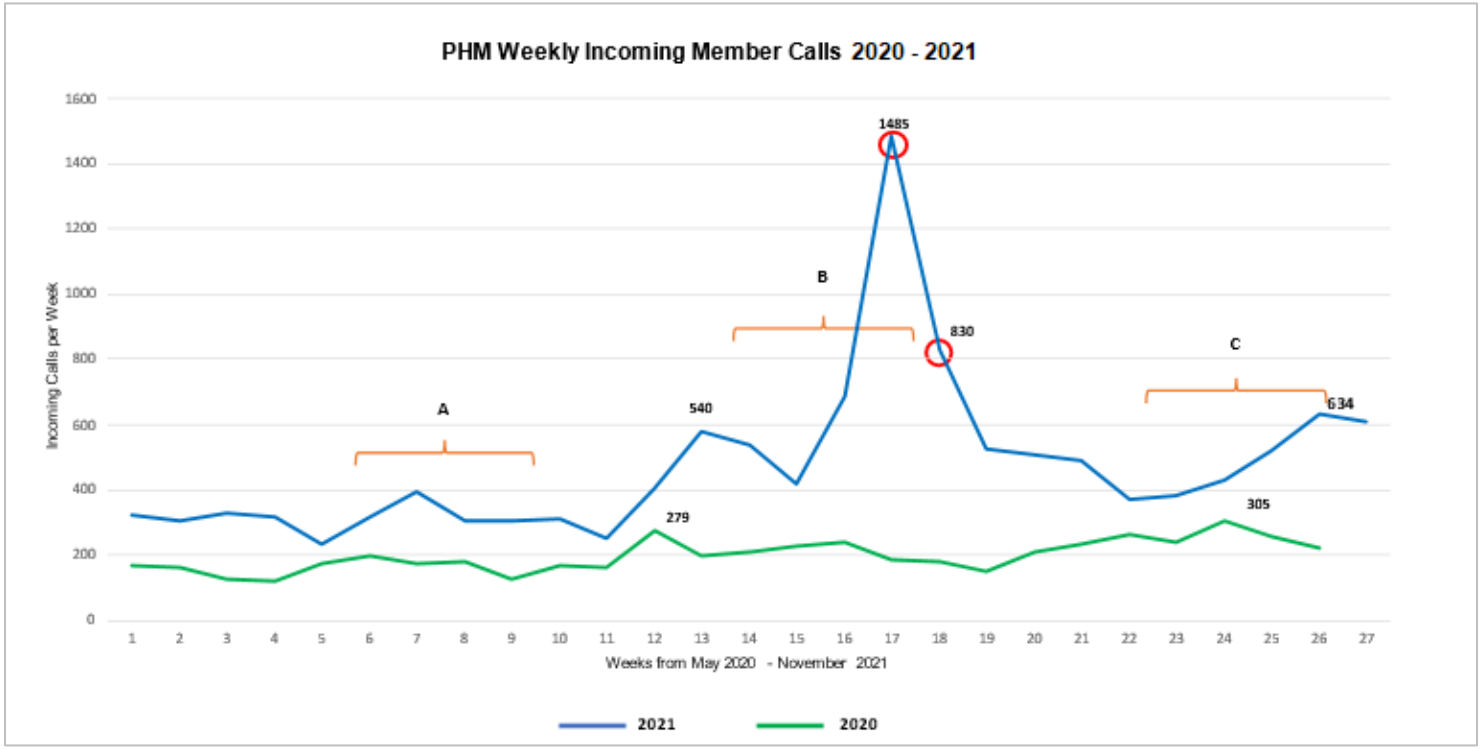
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

1. Previous Board Action January 7, 2021: Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021
2. Previous Board Action January 7, 2021: Consider Authorizing Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy in Response to the Coronavirus Pandemic
3. Previous Board Action March 4, 2021: Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program
4. Previous Board Action October 7, 2021: Consider Appropriation of Funds and Authorization of Unbudgeted Expenditures and Other Actions as Necessary to Implement the All-Plan Letter (APL) 21-010: Medi-Cal COVID-19 Vaccination Incentive Program

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

Population Health Management Weekly Incoming Call Volume Analysis 2020-2021



A. Weeks 5-9 represent the time period in the month of June 2021 were 141,000 gift cards were processed. Within a two-week time frame the incoming calls to the Population Health Management (PHM) department jumped from an average of 175 per week to 540 calls per week at the peak level.

B. Weeks 14-17 represent the time period in the month of August in which the internal address and privacy breach occurred. At this point in time 50,000 gift cards were deactivated. Within one week the call volume to the PHM department escalated to almost 1500 calls in one week.

C. Weeks 23-26 represent the time period in which 90,000 gift cards were processed. An increase in incoming calls to the PHM department occurred with the peak point reaching 634 calls in one week.

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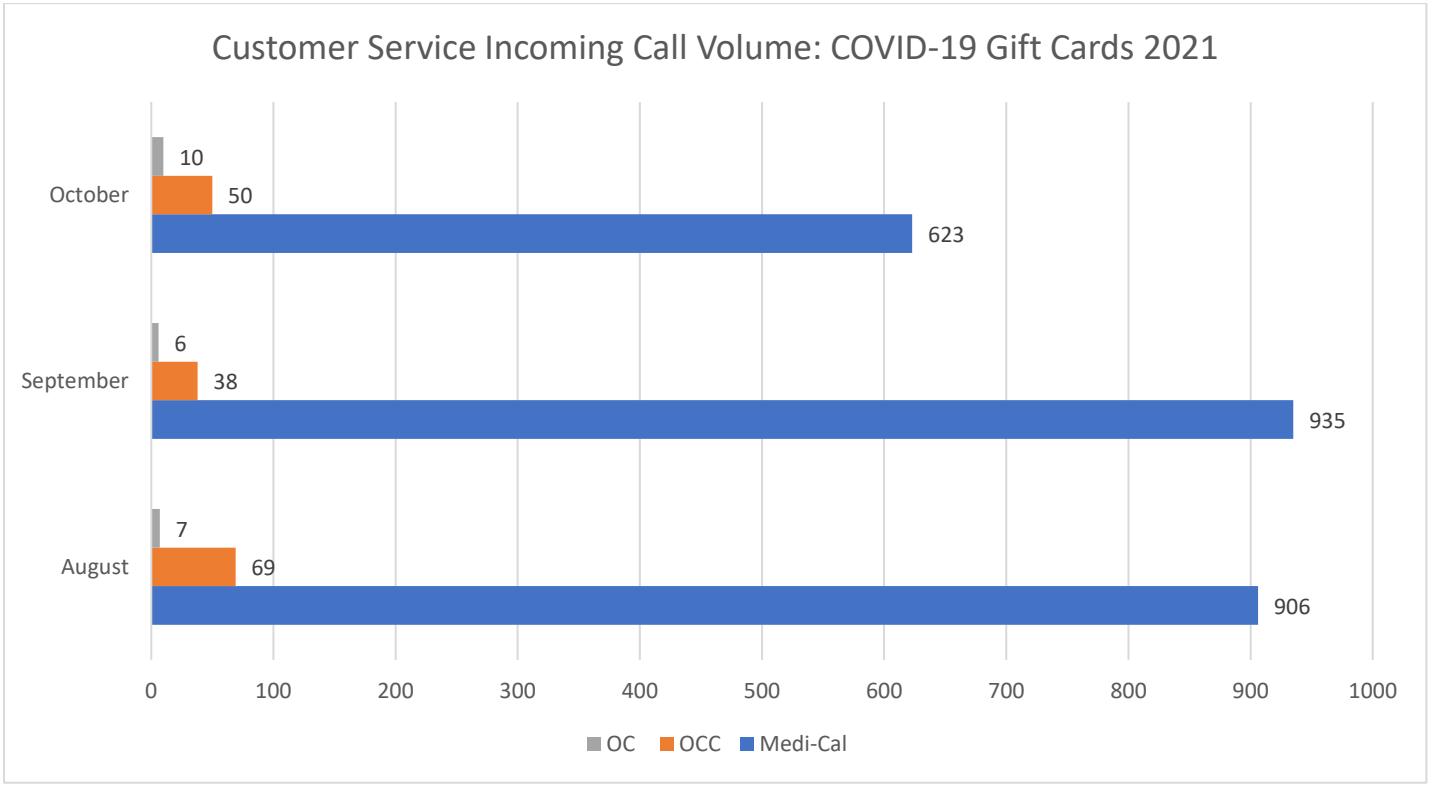
Customer Service Incoming Call Volumes COVID-19 Incentive Related Aug – Oct 2021



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Intergovernmental Transfers (IGT) 10 Summary

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions.

For the DHCS approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. CalOptima's share of IGT 10 funds is $63.57 million ($45.15 million was received in May 2021 and $18.42 million was received in December 2021). As of December 20, 2021, the CalOptima Board of Directors has allocated $36.48 million of IGT 10 funds, leaving $27.09 million unallocated as follows:

Date	Initiative	Amount
	Total Received	**$63.57 million**
1/7/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion	$1.2 million
1/7/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021- Member Incentive	$35.0 million
3/4/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021- Staffing	$221,145
12/20/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion CY2021	$61,000
	Total Allocated	**$36.48 million**
	Unallocated	**$27.09 million**
	Allocation Recommended in this Board Action Request	**$421,200**

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS in the year received and thus will have an impact on medical loss ratio (MLR) and administrative loss ratio (ALR), in that year. Similarly, amounts will have an impact on MLR and ALR in the year the funds are spent. To the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's ALR.

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CalOptima

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Financial Summary

November 30, 2021

February 3, 2022

Board of Directors Meeting

Nancy Huang, Chief Financial Officer

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Financial Highlights: November 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
867,182	844,253	22,929	2.7%	Member Months	4,284,488	4,207,610	76,878	1.8%
351,422,084	332,101,512	19,320,572	5.8%	Revenues	1,911,963,696	1,655,591,903	256,371,793	15.5%
310,764,003	323,245,128	12,481,125	3.9%	Medical Expenses	1,806,238,653	1,615,516,536	(190,722,117)	(11.8%)
12,530,903	14,810,839	2,279,936	15.4%	Administrative Expenses	59,509,530	72,385,676	12,876,146	17.8%
28,127,178	**(5,954,455)**	**34,081,633**	**572.4%**	**Operating Margin**	**46,215,513**	**(32,310,309)**	**78,525,822**	**243.0%**
(288,986)	833,333	(1,122,319)	(134.7%)	Non Operating Income (Loss)	(444,901)	4,166,666	(4,611,567)	(110.7%)
27,838,192	**(5,121,122)**	**32,959,314**	**643.6%**	**Change in Net Assets**	**45,770,612**	**(28,143,643)**	**73,914,255**	**262.6%**
88.4%	97.3%	8.9%		Medical Loss Ratio	94.5%	97.6%	3.1%	
3.6%	4.5%	0.9%		Administrative Loss Ratio	3.1%	4.4%	1.3%	
8.0%	(1.8%)	9.8%		Operating Margin Ratio	2.4%	(2.0%)	4.4%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
88.4%	97.3%	8.9%		*MLR (excluding Directed Payments)	94.1%	97.6%	3.5%	
3.6%	4.5%	0.9%		*ALR (excluding Directed Payments)	3.3%	4.4%	1.0%	

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

CalOptima
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Performance Snapshot: November 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
25.4	(5.7)	31.1	Medi-Cal	39.6	(30.4)	70.0
2.1	(0.3)	2.4	OCC	5.1	(2.1)	7.2
0.1	(0.1)	0.2	OneCare	(0.0)	(0.6)	0.5
0.5	0.2	0.3	PACE	1.5	0.8	0.8
28.1	**(6.0)**	**34.1**	**Operating**	**46.2**	**(32.3)**	**78.5**
(0.3)	0.8	(1.1)	Inv./Rental Inc, MCO tax	(0.4)	4.2	(4.6)
(0.3)	**0.8**	**(1.1)**	**Non-Operating**	**(0.4)**	**4.2**	**(4.6)**
27.8	**(5.1)**	**33.0**	**TOTAL**	**45.8**	**(28.1)**	**73.9**

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CalOptima
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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD (Nov 2021): $27.8 million, favorable to budget $33.0 million or 643.6%
  - YTD (Jul – Nov 2021): $45.8 million, favorable to budget $73.9 million or 262.6%
- Enrollment
  - MTD: 867,182 members, favorable to budget 22,929 or 2.7%
  - YTD: 4,284,488 members, favorable to budget 76,878 or 1.8%
- Revenue
  - MTD: $351.4 million, favorable to budget $19.3 million or 5.8% driven by Medi-Cal (MC) line of business (LOB):
    - $12.0 million due to the extension of Proposition 56 and updates to the Proposition 56 risk corridor
    - $8.2 million due to favorable enrollment
  - YTD: $1.9 billion, favorable to budget $256.4 million or 15.5% driven by MC LOB:
    - $132.6 million of FY 2020 hospital Directed Payments (DP)
    - $75.2 million due to the extension of Proposition 56 and updates to the Proposition 56 risk corridor
    - $23.3 million increase in Long-Term Care (LTC), pharmacy funding from DHCS, and Coordinated Care Initiative (CCI)
    - $27.5 million due to favorable enrollment

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $310.8 million, favorable to budget $12.5 million or 3.9% driven by MC LOB:
    - Provider Capitation expense unfavorable variance of $9.7 million due to Proposition 56 estimates and short-term supplemental rate increase due to COVID-19
    - Favorable variance of $19.4 million in all other medical expense categories, with the exception of Reinsurance & Other, due to deferred and delayed services
  - YTD: $1.8 billion, unfavorable to budget $190.7 million or 11.8% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $140.6 million due to Fiscal Year (FY) 2020 DP
    - Provider Capitation expense unfavorable variance of $74.3 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
- Administrative Expenses
  - MTD: $12.5 million, favorable to budget $2.3 million or 15.4%
  - YTD: $59.5 million, favorable to budget $12.9 million or 17.8%
- Net Investment & Other Income
  - MTD: ($0.3) million, unfavorable to budget $1.1 million or 134.7%
  - YTD: ($0.4) million, unfavorable to budget $4.6 million or 110.7%
  - Unfavorable variance is primarily driven by unrealized losses due to the recent increases in interest rates resulting in lower bond value

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 88.4%, Budget 97.3%
  - YTD: Actual 94.5% (94.1% excluding DP), Budget 97.6%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.6% , Budget 4.5%
  - YTD: Actual 3.1% (3.3% excluding DP), Budget 4.4%
- Balance Sheet Ratios
  - *Current ratio: 1.69
  - Board-designated reserve funds level: 1.70
  - Net position: $1.4 billion, including required Tangible Net Equity (TNE) of $107.2 million

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

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Enrollment Summary: November 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
119,466	117,307	2,159	1.8%	SPD	592,066	585,503	6,563	1.1%
300,518	297,084	3,434	1.2%	TANF Child	1,497,284	1,484,089	13,195	0.9%
113,407	107,177	6,230	5.8%	TANF Adult	553,840	533,452	20,388	3.8%
3,186	3,191	(5)	(0.2%)	LTC	15,660	15,955	(295)	(1.8%)
301,312	291,018	10,294	3.5%	MCE	1,479,604	1,446,693	32,911	2.3%
11,727	11,159	568	5.1%	WCM	59,163	55,795	3,368	6.0%
849,616	**826,936**	**22,680**	**2.7%**	**Medi-Cal Total**	**4,197,617**	**4,121,487**	**76,130**	**1.8%**
14,877	**15,133**	**(256)**	**(1.7%)**	**OneCare Connect**	**74,034**	**75,291**	**(1,257)**	**(1.7%)**
2,274	**1,780**	**494**	**27.8%**	**OneCare**	**10,787**	**8,839**	**1,948**	**22.0%**
415	**404**	**11**	**2.7%**	**PACE**	**2,050**	**1,993**	**57**	**2.9%**
867,182	**844,253**	**22,929**	**2.7%**	**CalOptima Total**	**4,284,488**	**4,207,610**	**76,878**	**1.8%**

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Consolidated Revenue & Expenses: November 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	536,577	301,312	11,727	849,616	14,877	2,274	415	867,182
REVENUES								
Capitation Revenue	159,941,078	$ 133,909,178	$ 24,910,626	$ 318,760,882	$ 26,371,390	$ 3,082,256	$ 3,207,556	$ 351,422,084
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	159,941,078	133,909,178	24,910,626	318,760,882	26,371,390	3,082,256	3,207,556	351,422,084
MEDICAL EXPENSES								
Provider Capitation	42,402,076	46,941,261	9,545,769	98,889,106	10,439,238	773,249		110,101,594
Facilities	19,773,053	22,617,550	3,664,505	46,055,108	3,028,703	928,535	708,621	50,720,968
Professional Claims	19,128,532	10,430,227	1,243,877	30,802,636	1,081,645	52,692	647,789	32,584,762
Prescription Drugs	20,089,090	28,346,597	6,775,218	55,210,905	5,678,433	915,647	281,064	62,086,050
MLTSS	35,742,389	3,844,384	2,072,130	41,658,904	1,151,630	78,698	9,786	42,899,017
Medical Management	2,490,386	1,497,157	315,830	4,303,373	1,035,462	28,360	803,134	6,170,329
Quality Incentives	2,424,944	1,066,716	108,561	3,600,221	234,555		5,188	3,839,963
Reinsurance & Other	1,268,450	803,630	9,979	2,082,059	149,395	8,250	121,617	2,361,321
Total Medical Expenses	143,318,920	115,547,522	23,735,870	282,602,312	22,799,061	2,785,431	2,577,199	310,764,003
Medical Loss Ratio	89.6%	86.3%	95.3%	88.7%	86.5%	90.4%	80.3%	88.4%
GROSS MARGIN	**16,622,158**	**18,361,656**	**1,174,756**	**36,158,570**	**3,572,329**	**296,825**	**630,358**	**40,658,081**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,004,034	651,457	71,471	101,085	7,828,048
Professional fees				416,386	50,000	29,167		495,552
Purchased services				1,078,334	102,979	10,770	624	1,192,706
Printing & Postage				286,021	149,322	33,872	11	469,227
Depreciation & Amortization				362,131			346	362,477
Other expenses				1,839,056	398	205	4,440	1,844,099
Indirect cost allocation & Occupancy				(227,684)	507,123	50,339	9,018	338,795
Total Administrative Expenses				10,758,278	1,461,279	195,823	115,523	12,530,903
Admin Loss Ratio				3.4%	5.5%	6.4%	3.6%	3.6%
INCOME (LOSS) FROM OPERATIONS				25,400,292	2,111,050	101,002	514,834	28,127,178
INVESTMENT INCOME								(751,167)
TOTAL MCO TAX				453,689				453,689
OTHER INCOME				8,493				8,493
CHANGE IN NET ASSETS				**$ 25,862,473**	**$ 2,111,050**	**$ 101,002**	**$ 514,834**	**$ 27,838,192**
BUDGETED CHANGE IN NET ASSETS				(5,684,883)	(329,957)	(106,011)	166,396	(5,121,122)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 31,547,356	$ 2,441,007	$ 207,013	$ 348,438	$ 32,959,314

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Consolidated Revenue & Expenses: November 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,658,850	1,479,604	59,163	4,197,617	74,034	10,787	2,050	4,284,488
REVENUES								
Capitation Revenue	894,309,753	$ 726,072,494	$ 124,906,005	$ 1,745,288,251	$ 135,885,426	$ 14,316,710	$ 16,473,309	$ 1,911,963,696
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	894,309,753	726,072,494	124,906,005	1,745,288,251	135,885,426	14,316,710	16,473,309	1,911,963,696
MEDICAL EXPENSES								
Provider Capitation	227,611,629	248,345,489	46,906,107	522,863,226	53,999,033	3,843,062		580,705,320
Facilities	123,217,270	118,672,362	28,327,692	270,217,323	19,684,390	4,023,896	3,738,103	297,663,711
Professional Claims	111,196,174	54,858,198	7,414,732	173,469,104	5,543,099	509,217	3,856,599	183,378,019
Prescription Drugs	108,962,570	147,245,507	32,595,517	288,803,593	30,019,632	4,533,866	1,620,870	324,977,961
MLTSS	190,070,209	20,615,294	10,227,900	220,913,402	6,946,855	373,088	268,646	228,501,992
Medical Management	12,319,839	7,261,003	1,566,142	21,146,985	5,135,921	157,840	4,070,110	30,510,856
Quality Incentives	8,347,532	4,883,161	320,922	13,551,615	1,124,010		25,625	14,701,250
Reinsurance & Other	90,337,476	53,747,341	52,439	144,137,256	1,046,832	12,632	602,823	145,799,543
Total Medical Expenses	872,062,700	655,628,354	127,411,449	1,655,102,504	123,499,773	13,453,600	14,182,776	1,806,238,653
Medical Loss Ratio	97.5%	90.3%	102.0%	94.8%	90.9%	94.0%	86.1%	94.5%
GROSS MARGIN	**22,247,052**	**70,444,139**	**(2,505,444)**	**90,185,747**	**12,385,653**	**863,110**	**2,290,532**	**105,725,043**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				34,829,724	3,660,831	386,085	565,061	39,441,702
Professional fees				959,336	144,581	152,599	5,716	1,262,233
Purchased services				4,678,608	487,781	54,447	40,457	5,261,293
Printing & Postage				1,467,300	437,992	61,100	51,700	2,018,091
Depreciation & Amortization				1,951,828			5,701	1,957,529
Other expenses				7,535,710	5,705	410	35,967	7,577,791
Indirect cost allocation & Occupancy				(841,065)	2,535,613	251,694	44,650	1,990,891
Total Administrative Expenses				50,581,442	7,272,503	906,334	749,252	59,509,530
Admin Loss Ratio				2.9%	5.4%	6.3%	4.5%	3.1%
INCOME (LOSS) FROM OPERATIONS				39,604,306	5,113,150	(43,224)	1,541,281	46,215,513
INVESTMENT INCOME								(1,872,507)
TOTAL MCO TAX				1,418,988				1,418,988
OTHER INCOME				8,618				8,618
CHANGE IN NET ASSETS				**$ 41,031,912**	**$ 5,113,150**	**$ (43,224)**	**$ 1,541,281**	**$ 45,770,612**
BUDGETED CHANGE IN NET ASSETS				(30,385,904)	(2,130,450)	(580,615)	786,660	(28,143,643)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 71,417,816	$ 7,243,600	$ 537,391	$ 754,621	$ 73,914,255

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Balance Sheet: As of November 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$152,611,818	Accounts Payable	$34,216,093
Short-term Investments	975,083,742	Medical Claims liability	817,052,780
Capitation receivable	553,976,291	Accrued Payroll Liabilities	14,560,755
Receivables - Other	60,596,590	Deferred Revenue	9,479,216
Prepaid expenses	11,198,154	Deferred Lease Obligations	124,462
		Capitation and Withholds	161,113,436
Total Current Assets	**1,753,466,595**	**Total Current Liabilities**	**1,036,546,741**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	7,084,715		
505 City Parkway West	51,777,223		
	105,113,023		
Less: accumulated depreciation	(60,506,042)		
Capital assets, net	44,606,981	Other (than pensions) post employment benefits liability	31,825,622
Other Assets		Net Pension Liabilities	30,225,137
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,098,597,501**
Cash and Cash Equivalents	3,062,594		
Investments	584,284,668	**Deferred Inflows**	
Total Board-designated Assets	587,347,262	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	644,446,175	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,442,519,751**	TNE	107,228,877
		Funds in Excess of TNE	1,247,322,528
Deferred Outflows		**TOTAL NET POSITION**	1,354,551,405
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,457,512,048**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,457,512,048**

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Board Designated Reserve and TNE Analysis: As of November 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	240,598,181				
	Tier 1 - MetLife	239,540,029				
Board-designated Reserve		480,138,210	377,163,624	584,760,411	102,974,586	(104,622,201)
	Tier 2 - Payden & Rygel	53,618,197				
	Tier 2 - MetLife	53,590,854				
TNE Requirement		107,209,051	107,228,877	107,228,877	(19,826)	(19,826)
	Consolidated:	**587,347,262**	**484,392,502**	**691,989,288**	**102,954,760**	**(104,642,026)**
	Current reserve level	*1.70*	*1.40*	*2.00*		

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Our Mission

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

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UNAUDITED FINANCIAL STATEMENTS

November 2021

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CalOptima - Consolidated
Financial Highlights
For the Five Months Ended November 30, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
867,182	844,253	22,929	2.7%	Member Months	4,284,488	4,207,610	76,878	1.8%
351,422,084	332,101,512	19,320,572	5.8%	Revenues	1,911,963,696	1,655,591,903	256,371,793	15.5%
310,764,003	323,245,128	12,481,125	3.9%	Medical Expenses	1,806,238,653	1,615,516,536	(190,722,117)	(11.8%)
12,530,903	14,810,839	2,279,936	15.4%	Administrative Expenses	59,509,530	72,385,676	12,876,146	17.8%
28,127,178	**(5,954,455)**	**34,081,633**	**572.4%**	**Operating Margin**	**46,215,513**	**(32,310,309)**	**78,525,822**	**243.0%**
(288,986)	833,333	(1,122,319)	(134.7%)	Non Operating Income (Loss)	(444,901)	4,166,666	(4,611,567)	(110.7%)
27,838,192	**(5,121,122)**	**32,959,314**	**643.6%**	**Change in Net Assets**	**45,770,612**	**(28,143,643)**	**73,914,255**	**262.6%**
88.4%	97.3%	8.9%		Medical Loss Ratio	94.5%	97.6%	3.1%	
3.6%	4.5%	0.9%		Administrative Loss Ratio	3.1%	4.4%	1.3%	
8.0%	(1.8%)	9.8%		Operating Margin Ratio	2.4%	(2.0%)	4.4%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
88.4%	97.3%	8.9%		*MLR (excluding Directed Payments)	94.1%	97.6%	3.5%	
3.6%	4.5%	0.9%		*ALR (excluding Directed Payments)	3.3%	4.4%	1.0%	

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

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CalOptima
Financial Dashboard
For the Five Months Ended November 30, 2021

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	849,616	826,936	22,680	2.7%
OneCare Connect	14,877	15,133	(256)	(1.7%)
OneCare	2,274	1,780	494	27.8%
PACE	415	404	11	2.7%
Total	867,182	844,253	22,929	2.7%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 25,862	$ (5,685)	$ 31,547	554.9%
OneCare Connect	2,111	(330)	2,441	739.7%
OneCare	101	(106)	207	195.3%
PACE	515	166	349	210.2%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	(751)	833	(1,584)	(190.2%)
Total	$ 27,838	$ (5,122)	$ 32,960	643.5%

MLR

	Actual	Budget	% Point Var
Medi-Cal	88.7%	97.7%	9.1
OneCare Connect	86.5%	94.5%	8.1
OneCare	90.4%	96.4%	6.0

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,758	$ 12,564	$ 1,806	14.4%
OneCare Connect	1,461	1,839	378	20.5%
OneCare	196	179	(16)	(9.1%)
PACE	116	228	112	49.3%
Total	$ 12,531	$ 14,811	$ 2,280	15.4%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,091	1,221	130
OneCare Connect	184	210	25
OneCare	10	9	(1)
PACE	91	115	24
Total	1,376	1,554	178

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	779	677	101
OneCare Connect	81	72	9
OneCare	229	191	38
PACE	5	4	1
Total	1,093	944	149

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	4,197,617	4,121,487	76,130	1.8%
OneCare Connect	74,034	75,291	(1,257)	(1.7%)
OneCare	10,787	8,839	1,948	22.0%
PACE	2,050	1,993	57	2.9%
Total	4,284,488	4,207,610	76,878	1.8%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 41,032	$ (30,386)	$ 71,418	235.0%
OneCare Connect	5,113	(2,130)	7,243	340.0%
OneCare	(43)	(581)	538	92.6%
PACE	1,541	787	754	95.8%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	(1,873)	4,167	(6,040)	(144.9%)
Total	$ 45,770	$ (28,143)	$ 73,913	262.6%

MLR

	Actual	Budget	% Point Var
Medi-Cal	94.8%	97.9%	3.1
OneCare Connect	90.9%	94.8%	3.9
OneCare	94.0%	96.9%	2.9

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 50,581	$ 61,086	$ 10,504	17.2%
OneCare Connect	7,273	9,308	2,035	21.9%
OneCare	906	896	(10)	(1.1%)
PACE	749	1,096	347	31.6%
Total	$ 59,510	$ 72,386	$ 12,876	17.8%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	5,384	6,085	701
OneCare Connect	954	1,047	93
OneCare	49	47	(3)
PACE	459	564	104
Total	6,847	7,742	895

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	780	677	102
OneCare Connect	78	72	6
OneCare	219	190	29
PACE	4	4	1
Total	1,081	943	138

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

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	867,182		844,253		22,929	
REVENUE						
Medi-Cal	$ 318,760,882	$ 375.18	$ 299,244,444	$ 361.87	$ 19,516,438	$ 13.31
OneCare Connect	26,371,390	1,772.63	27,536,765	1,819.65	(1,165,375)	(47.02)
OneCare	3,082,256	1,355.43	2,043,081	1,147.80	1,039,175	207.63
PACE	3,207,556	7,729.05	3,277,222	8,111.94	(69,666)	(382.89)
Total Operating Revenue	351,422,084	405.25	332,101,512	393.37	19,320,572	11.88
MEDICAL EXPENSES						
Medi-Cal	282,602,312	332.62	292,365,140	353.55	9,762,828	20.93
OneCare Connect	22,799,061	1,532.50	26,027,491	1,719.92	3,228,430	187.42
OneCare	2,785,431	1,224.90	1,969,671	1,106.56	(815,760)	(118.34)
PACE	2,577,199	6,210.12	2,882,826	7,135.71	305,627	925.59
Total Medical Expenses	310,764,003	358.36	323,245,128	382.88	12,481,125	24.52
GROSS MARGIN	40,658,081	46.89	8,856,384	10.49	31,801,697	36.40
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,828,048	9.03	9,435,949	11.18	1,607,901	2.15
Professional fees	495,552	0.57	757,255	0.90	261,703	0.33
Purchased services	1,192,706	1.38	1,336,849	1.58	144,143	0.20
Printing & Postage	469,227	0.54	556,998	0.66	87,771	0.12
Depreciation & Amortization	362,477	0.42	492,900	0.58	130,423	0.16
Other expenses	1,844,099	2.13	1,791,954	2.12	(52,145)	(0.01)
Indirect cost allocation & Occupancy expense	338,795	0.39	438,934	0.52	100,139	0.13
Total Administrative Expenses	12,530,903	14.45	14,810,839	17.54	2,279,936	3.09
INCOME (LOSS) FROM OPERATIONS	28,127,178	32.44	(5,954,455)	(7.05)	34,081,633	39.49
INVESTMENT INCOME						
Interest income	699,256	0.81	833,333	0.99	(134,077)	(0.18)
Realized gain/(loss) on investments	(381,386)	(0.44)	-	-	(381,386)	(0.44)
Unrealized gain/(loss) on investments	(1,069,037)	(1.23)	-	-	(1,069,037)	(1.23)
Total Investment Income	(751,167)	(0.87)	833,333	0.99	(1,584,500)	(1.86)
TOTAL MCO TAX	453,689	0.52	-	-	453,689	0.52
OTHER INCOME	8,493	0.01	-	-	8,493	0.01
CHANGE IN NET ASSETS	**27,838,192**	**32.10**	**(5,121,122)**	**(6.07)**	**32,959,314**	**38.17**
MEDICAL LOSS RATIO	**88.4%**		**97.3%**		**8.9%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.5%**		**0.9%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	4,284,488		4,207,610		76,878	
REVENUE						
Medi-Cal	$ 1,745,288,251	$ 415.78	$ 1,491,385,595	$ 361.86	$ 253,902,656	$ 53.92
OneCare Connect	135,885,426	1,835.45	137,888,866	1,831.41	(2,003,440)	4.04
OneCare	14,316,710	1,327.22	10,157,408	1,149.16	4,159,302	178.06
PACE	16,473,309	8,035.76	16,160,034	8,108.40	313,275	(72.64)
Total Operating Revenue	1,911,963,696	446.25	1,655,591,903	393.48	256,371,793	52.77
MEDICAL EXPENSES						
Medi-Cal	1,655,102,504	394.30	1,460,685,830	354.41	(194,416,674)	(39.89)
OneCare Connect	123,499,773	1,668.15	130,711,548	1,736.08	7,211,775	67.93
OneCare	13,453,600	1,247.20	9,841,705	1,113.44	(3,611,895)	(133.76)
PACE	14,182,776	6,918.43	14,277,453	7,163.80	94,677	245.37
Total Medical Expenses	1,806,238,653	421.58	1,615,516,536	383.95	(190,722,117)	(37.63)
GROSS MARGIN	105,725,043	24.67	40,075,367	9.53	65,649,676	15.14
ADMINISTRATIVE EXPENSES						
Salaries and benefits	39,441,702	9.21	46,235,915	10.99	6,794,213	1.78
Professional fees	1,262,233	0.29	3,193,492	0.76	1,931,259	0.47
Purchased services	5,261,293	1.23	6,557,064	1.56	1,295,771	0.33
Printing & Postage	2,018,091	0.47	2,784,990	0.66	766,899	0.19
Depreciation & Amortization	1,957,529	0.46	2,464,500	0.59	506,971	0.13
Other expenses	7,577,791	1.77	8,955,045	2.13	1,377,254	0.36
Indirect cost allocation & Occupancy expense	1,990,891	0.46	2,194,670	0.52	203,779	0.06
Total Administrative Expenses	59,509,530	13.89	72,385,676	17.20	12,876,146	3.31
INCOME (LOSS) FROM OPERATIONS	46,215,513	10.79	(32,310,309)	(7.68)	78,525,822	18.47
INVESTMENT INCOME						
Interest income	3,063,798	0.72	4,166,666	0.99	(1,102,868)	(0.27)
Realized gain/(loss) on investments	294,008	0.07	-	-	294,008	0.07
Unrealized gain/(loss) on investments	(5,230,313)	(1.22)	-	-	(5,230,313)	(1.22)
Total Investment Income	(1,872,507)	(0.44)	4,166,666	0.99	(6,039,173)	(1.43)
TOTAL MCO TAX	1,418,988	0.33	-	-	1,418,988	0.33
OTHER INCOME	8,618	-	-	-	8,618	-
CHANGE IN NET ASSETS	**45,770,612**	**10.68**	**(28,143,643)**	**(6.69)**	**73,914,255**	**17.37**
MEDICAL LOSS RATIO	**94.5%**		**97.6%**		**3.1%**	
ADMINISTRATIVE LOSS RATIO	**3.1%**		**4.4%**		**1.3%**	

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

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	536,577	301,312	11,727	849,616	14,877	2,274	415	867,182
REVENUES								
Capitation Revenue	159,941,078	$ 133,909,178	$ 24,910,626	$ 318,760,882	$ 26,371,390	$ 3,082,256	$ 3,207,556	$ 351,422,084
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	159,941,078	133,909,178	24,910,626	318,760,882	26,371,390	3,082,256	3,207,556	351,422,084
MEDICAL EXPENSES								
Provider Capitation	42,402,076	46,941,261	9,545,769	98,889,106	10,439,238	773,249		110,101,594
Facilities	19,773,053	22,617,550	3,664,505	46,055,108	3,028,703	928,535	708,621	50,720,968
Professional Claims	19,128,532	10,430,227	1,243,877	30,802,636	1,081,645	52,692	647,789	32,584,762
Prescription Drugs	20,089,090	28,346,597	6,775,218	55,210,905	5,678,433	915,647	281,064	62,086,050
MLTSS	35,742,389	3,844,384	2,072,130	41,658,904	1,151,630	78,698	9,786	42,899,017
Medical Management	2,490,386	1,497,157	315,830	4,303,373	1,035,462	28,360	803,134	6,170,329
Quality Incentives	2,424,944	1,066,716	108,561	3,600,221	234,555		5,188	3,839,963
Reinsurance & Other	1,268,450	803,630	9,979	2,082,059	149,395	8,250	121,617	2,361,321
Total Medical Expenses	143,318,920	115,547,522	23,735,870	282,602,312	22,799,061	2,785,431	2,577,199	310,764,003
Medical Loss Ratio	89.6%	86.3%	95.3%	88.7%	86.5%	90.4%	80.3%	88.4%
GROSS MARGIN	**16,622,158**	**18,361,656**	**1,174,756**	**36,158,570**	**3,572,329**	**296,825**	**630,358**	**40,658,081**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,004,034	651,457	71,471	101,085	7,828,048
Professional fees				416,386	50,000	29,167		495,552
Purchased services				1,078,334	102,979	10,770	624	1,192,706
Printing & Postage				286,021	149,322	33,872	11	469,227
Depreciation & Amortization				362,131			346	362,477
Other expenses				1,839,056	398	205	4,440	1,844,099
Indirect cost allocation & Occupancy				(227,684)	507,123	50,339	9,018	338,795
Total Administrative Expenses				10,758,278	1,461,279	195,823	115,523	12,530,903
Admin Loss Ratio				3.4%	5.5%	6.4%	3.6%	3.6%
INCOME (LOSS) FROM OPERATIONS				25,400,292	2,111,050	101,002	514,834	28,127,178
INVESTMENT INCOME								(751,167)
TOTAL MCO TAX				453,689				453,689
OTHER INCOME				8,493				8,493
CHANGE IN NET ASSETS				**$ 25,862,473**	**$ 2,111,050**	**$ 101,002**	**$ 514,834**	**$ 27,838,192**
BUDGETED CHANGE IN NET ASSETS				(5,684,883)	(329,957)	(106,011)	166,396	(5,121,122)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 31,547,356	$ 2,441,007	$ 207,013	$ 348,438	$ 32,959,314

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

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,658,850	1,479,604	59,163	4,197,617	74,034	10,787	2,050	4,284,488
REVENUES								
Capitation Revenue	894,309,753	$ 726,072,494	$ 124,906,005	$ 1,745,288,251	$ 135,885,426	$ 14,316,710	$ 16,473,309	$ 1,911,963,696
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	894,309,753	726,072,494	124,906,005	1,745,288,251	135,885,426	14,316,710	16,473,309	1,911,963,696
MEDICAL EXPENSES								
Provider Capitation	227,611,629	248,345,489	46,906,107	522,863,226	53,999,033	3,843,062		580,705,320
Facilities	123,217,270	118,672,362	28,327,692	270,217,323	19,684,390	4,023,896	3,738,103	297,663,711
Professional Claims	111,196,174	54,858,198	7,414,732	173,469,104	5,543,099	509,217	3,856,599	183,378,019
Prescription Drugs	108,962,570	147,245,507	32,595,517	288,803,593	30,019,632	4,533,866	1,620,870	324,977,961
MLTSS	190,070,209	20,615,294	10,227,900	220,913,402	6,946,855	373,088	268,646	228,501,992
Medical Management	12,319,839	7,261,003	1,566,142	21,146,985	5,135,921	157,840	4,070,110	30,510,856
Quality Incentives	8,347,532	4,883,161	320,922	13,551,615	1,124,010		25,625	14,701,250
Reinsurance & Other	90,337,476	53,747,341	52,439	144,137,256	1,046,832	12,632	602,823	145,799,543
Total Medical Expenses	872,062,700	655,628,354	127,411,449	1,655,102,504	123,499,773	13,453,600	14,182,776	1,806,238,653
Medical Loss Ratio	97.5%	90.3%	102.0%	94.8%	90.9%	94.0%	86.1%	94.5%
GROSS MARGIN	**22,247,052**	**70,444,139**	**(2,505,444)**	**90,185,747**	**12,385,653**	**863,110**	**2,290,532**	**105,725,043**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				34,829,724	3,660,831	386,085	565,061	39,441,702
Professional fees				959,336	144,581	152,599	5,716	1,262,233
Purchased services				4,678,608	487,781	54,447	40,457	5,261,293
Printing & Postage				1,467,300	437,992	61,100	51,700	2,018,091
Depreciation & Amortization				1,951,828			5,701	1,957,529
Other expenses				7,535,710	5,705	410	35,967	7,577,791
Indirect cost allocation & Occupancy				(841,065)	2,535,613	251,694	44,650	1,990,891
Total Administrative Expenses				50,581,442	7,272,503	906,334	749,252	59,509,530
Admin Loss Ratio				2.9%	5.4%	6.3%	4.5%	3.1%
INCOME (LOSS) FROM OPERATIONS				39,604,306	5,113,150	(43,224)	1,541,281	46,215,513
INVESTMENT INCOME								(1,872,507)
TOTAL MCO TAX				1,418,988				1,418,988
OTHER INCOME				8,618				8,618
CHANGE IN NET ASSETS				**$ 41,031,912**	**$ 5,113,150**	**$ (43,224)**	**$ 1,541,281**	**$ 45,770,612**
BUDGETED CHANGE IN NET ASSETS				(30,385,904)	(2,130,450)	(580,615)	786,660	(28,143,643)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 71,417,816	$ 7,243,600	$ 537,391	$ 754,621	$ 73,914,255

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November 30, 2021 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $27.8 million, $33.0 million favorable to budget
- Operating surplus is $28.1 million, with a deficit in non-operating income of $0.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $45.8 million, $73.9 million favorable to budget
- Operating surplus is $46.2 million, with a deficit in non-operating income of $0.4 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
25.4	(5.7)	31.1	Medi-Cal	39.6	(30.4)	70.0
2.1	(0.3)	2.4	OCC	5.1	(2.1)	7.2
0.1	(0.1)	0.2	OneCare	(0.0)	(0.6)	0.5
0.5	0.2	0.3	PACE	1.5	0.8	0.8
28.1	**(6.0)**	**34.1**	**Operating**	**46.2**	**(32.3)**	**78.5**
(0.3)	0.8	(1.1)	Inv./Rental Inc, MCO tax	(0.4)	4.2	(4.6)
(0.3)	**0.8**	**(1.1)**	**Non-Operating**	**(0.4)**	**4.2**	**(4.6)**
27.8	**(5.1)**	**33.0**	**TOTAL**	**45.8**	**(28.1)**	**73.9**

CalOptima - Consolidated
Enrollment Summary
For the Five Months Ended November 30, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
119,466	117,307	2,159	1.8%	SPD	592,066	585,503	6,563	1.1%
300,518	297,084	3,434	1.2%	TANF Child	1,497,284	1,484,089	13,195	0.9%
113,407	107,177	6,230	5.8%	TANF Adult	553,840	533,452	20,388	3.8%
3,186	3,191	(5)	(0.2%)	LTC	15,660	15,955	(295)	(1.8%)
301,312	291,018	10,294	3.5%	MCE	1,479,604	1,446,693	32,911	2.3%
11,727	11,159	568	5.1%	WCM	59,163	55,795	3,368	6.0%
849,616	**826,936**	**22,680**	**2.7%**	**Medi-Cal Total**	**4,197,617**	**4,121,487**	**76,130**	**1.8%**
14,877	**15,133**	**(256)**	**(1.7%)**	**OneCare Connect**	**74,034**	**75,291**	**(1,257)**	**(1.7%)**
2,274	**1,780**	**494**	**27.8%**	**OneCare**	**10,787**	**8,839**	**1,948**	**22.0%**
415	**404**	**11**	**2.7%**	**PACE**	**2,050**	**1,993**	**57**	**2.9%**
867,182	**844,253**	**22,929**	**2.7%**	**CalOptima Total**	**4,284,488**	**4,207,610**	**76,878**	**1.8%**
				Enrollment (by Network)				
197,621	191,741	5,880	3.1%	HMO	976,187	953,677	22,510	2.4%
229,927	228,026	1,901	0.8%	PHC	1,142,738	1,138,521	4,217	0.4%
207,770	203,322	4,448	2.2%	Shared Risk Group	1,026,994	1,014,308	12,686	1.3%
214,298	203,847	10,451	5.1%	Fee for Service	1,051,698	1,014,981	36,717	3.6%
849,616	**826,936**	**22,680**	**2.7%**	**Medi-Cal Total**	**4,197,617**	**4,121,487**	**76,130**	**1.8%**
14,877	**15,133**	**(256)**	**(1.7%)**	**OneCare Connect**	**74,034**	**75,291**	**(1,257)**	**(1.7%)**
2,274	**1,780**	**494**	**27.8%**	**OneCare**	**10,787**	**8,839**	**1,948**	**22.0%**
415	**404**	**11**	**2.7%**	**PACE**	**2,050**	**1,993**	**57**	**2.9%**
867,182	**844,253**	**22,929**	**2.7%**	**CalOptima Total**	**4,284,488**	**4,207,610**	**76,878**	**1.8%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2022

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,759	10,772	10,796	10,750	10,821								53,898	53,960	(62)
TANF Child	57,684	57,453	57,592	57,944	58,108								288,781	285,112	3,669
TANF Adult	33,827	34,099	34,339	34,622	35,046								171,933	165,562	6,371
LTC		1	3	1									5		5
MCE	88,797	89,334	90,159	91,017	91,516								450,823	438,993	11,830
WCM	2,114	2,193	2,177	2,133	2,130								10,747	10,050	697
Total	**193,181**	**193,852**	**195,066**	**196,467**	**197,621**								**976,187**	**953,677**	**22,510**
PHCs															
SPD	6,896	6,819	6,942	6,915	6,953								34,525	35,571	(1,046)
TANF Child	155,214	154,985	155,440	155,771	156,156								777,566	773,437	4,129
TANF Adult	14,006	14,054	14,197	14,390	14,667								71,314	68,924	2,390
LTC		2	1										3		3
MCE	44,256	44,359	44,580	44,754	44,973								222,922	226,229	(3,307)
WCM	7,304	7,368	7,236	7,322	7,178								36,408	34,360	2,048
Total	**227,676**	**227,587**	**228,396**	**229,152**	**229,927**								**1,142,738**	**1,138,521**	**4,217**
Shared Risk Groups															
SPD	10,063	10,104	10,074	10,003	10,122								50,366	51,624	(1,258)
TANF Child	59,085	58,837	58,641	58,541	58,523								293,627	297,794	(4,167)
TANF Adult	33,013	33,123	33,374	33,745	34,109								167,364	165,448	1,916
LTC	1	1	1		1								4		4
MCE	99,994	100,643	101,666	102,780	103,620								508,703	492,362	16,341
WCM	1,373	1,368	1,394	1,400	1,395								6,930	7,080	(150)
Total	**203,529**	**204,076**	**205,150**	**206,469**	**207,770**								**1,026,994**	**1,014,308**	**12,686**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139	80,438	80,738								401,261	392,553	8,708
TANF Child	1	1	1	1	1								5		5
TANF Adult	1,318	1,351	1,392	1,408	1,435								6,904	5,809	1,095
LTC	2,788	2,778	2,806	2,847	2,864								14,083	14,435	(352)
MCE	3,612	3,813	4,013	4,268	4,489								20,195	12,941	7,254
WCM	16	16	18	20	15								85	75	10
Total	**87,564**	**88,076**	**88,369**	**88,982**	**89,542**								**442,533**	**425,813**	**16,720**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616	10,358	10,832								52,016	51,795	221
TANF Child	26,720	26,952	27,715	28,188	27,730								137,305	127,746	9,559
TANF Adult	26,224	26,653	27,382	27,916	28,150								136,325	127,709	8,616
LTC	309	314	305	316	321								1,565	1,520	45
MCE	53,947	54,384	55,449	56,467	56,714								276,961	276,168	793
WCM	993	962	999	1,030	1,009								4,993	4,230	763
Total	**118,356**	**119,312**	**122,466**	**124,275**	**124,756**								**609,165**	**589,168**	**19,997**
SPD	117,710	117,859	118,567	118,464	119,466								592,066	585,503	6,563
TANF Child	298,704	298,228	299,389	300,445	300,518								1,497,284	1,484,089	13,195
TANF Adult	108,388	109,280	110,684	112,081	113,407								553,840	533,452	20,388
LTC	3,098	3,096	3,116	3,164	3,186								15,660	15,955	(295)
MCE	290,606	292,533	295,867	299,286	301,312								1,479,604	1,446,693	32,911
WCM	11,800	11,907	11,824	11,905	11,727								59,163	55,795	3,368
Total Medi-Cal MM	**830,306**	**832,903**	**839,447**	**845,345**	**849,616**								**4,197,617**	**4,121,487**	**76,130**
OneCare Connect	**14,688**	**14,819**	**14,817**	**14,833**	**14,877**								**74,034**	**75,291**	**(1,257)**
OneCare	**2,019**	**2,110**	**2,152**	**2,232**	**2,274**								**10,787**	**8,839**	**1,948**
PACE	**401**	**407**	**409**	**418**	**415**								**2,050**	**1,993**	**57**
Grand Total	**847,414**	**850,239**	**856,825**	**862,828**	**867,182**								**4,284,488**	**4,207,610**	**76,878**

ENROLLMENT:

Overall, November enrollment was 867,182

- Favorable to budget 22,929 or 2.7%
- Increased 4,354 or 0.5% from Prior Month (PM) (October 2021)
- Increased 65,912 or 8.2% from Prior Year (PY) (November 2020)

Medi-Cal enrollment was 849,616

- Favorable to budget 22,680 or 2.7%
  - Medi-Cal Expansion (MCE) favorable 10,294
  - Temporary Assistance for Needy Families (TANF) favorable 9,664
  - Seniors and Persons with Disabilities (SPD) favorable 2,159
  - Whole Child Model (WCM) favorable 568
  - Long-Term Care (LTC) unfavorable 5
- Increased 4,271 from PM

OneCare Connect enrollment was 14,877

- Unfavorable to budget 256 or 1.7%
- Increased 44 from PM

OneCare enrollment was 2,274

- Favorable to budget 494 or 27.8%
- Increased 42 from PM

PACE enrollment was 415

- Favorable to budget 11 or 2.7%
- Decreased 3 from PM

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

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
849,616	**826,936**	**22,680**	**2.7%**	**Member Months**	**4,197,617**	**4,121,487**	**76,130**	**1.8%**
				Revenues				
318,760,882	299,244,444	19,516,438	6.5%	Capitation Revenue	1,745,288,251	1,491,385,595	253,902,656	17.0%
-	-	-	0.0%	Other Income	-	-	-	0.0%
318,760,882	**299,244,444**	**19,516,438**	**6.5%**	**Total Operating Revenue**	**1,745,288,251**	**1,491,385,595**	**253,902,656**	**17.0%**
				Medical Expenses				
102,489,327	92,815,836	(9,673,491)	(10.4%)	Provider Capitation	536,414,841	462,141,709	(74,273,132)	(16.1%)
46,055,108	63,926,593	17,871,485	28.0%	Facilities Claims	270,217,323	315,982,440	45,765,117	14.5%
30,802,636	31,050,618	247,982	0.8%	Professional Claims	173,469,104	155,512,053	(17,957,051)	(11.5%)
55,210,905	56,682,769	1,471,864	2.6%	Prescription Drugs	288,803,593	286,835,129	(1,968,464)	(0.7%)
41,658,904	41,734,126	75,222	0.2%	MLTSS	220,913,402	210,334,202	(10,579,200)	(5.0%)
4,303,373	5,454,516	1,151,143	21.1%	Medical Management	21,146,985	26,376,882	5,229,897	19.8%
2,082,059	700,682	(1,381,377)	(197.1%)	Reinsurance & Other	144,137,256	3,503,415	(140,633,841)	(4014.2%)
282,602,312	**292,365,140**	**9,762,828**	**3.3%**	**Total Medical Expenses**	**1,655,102,504**	**1,460,685,830**	**(194,416,674)**	**(13.3%)**
36,158,570	**6,879,304**	**29,279,266**	**425.6%**	**Gross Margin**	**90,185,747**	**30,699,765**	**59,485,982**	**193.8%**
				Administrative Expenses				
7,004,034	8,324,985	1,320,951	15.9%	Salaries, Wages & Employee Benefits	34,829,724	40,764,348	5,934,624	14.6%
416,386	716,172	299,786	41.9%	Professional Fees	959,336	2,838,077	1,878,741	66.2%
1,078,334	1,178,148	99,814	8.5%	Purchased Services	4,678,608	5,763,559	1,084,951	18.8%
286,021	383,828	97,807	25.5%	Printing and Postage	1,467,300	1,919,140	451,840	23.5%
362,131	492,500	130,369	26.5%	Depreciation & Amortization	1,951,828	2,462,500	510,672	20.7%
1,839,056	1,765,541	(73,515)	(4.2%)	Other Operating Expenses	7,535,710	8,822,980	1,287,270	14.6%
(227,684)	(296,987)	(69,303)	(23.3%)	Indirect Cost Allocation, Occupancy Expense	(841,065)	(1,484,935)	(643,870)	(43.4%)
10,758,278	**12,564,187**	**1,805,909**	**14.4%**	**Total Administrative Expenses**	**50,581,442**	**61,085,669**	**10,504,227**	**17.2%**
				Operating Tax				
14,307,855	13,925,610	382,245	2.7%	Tax Revenue	70,689,821	69,405,843	1,283,978	1.8%
13,854,167	13,925,610	71,443	0.5%	Premium Tax Expense	69,270,833	69,405,843	135,010	0.2%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
453,689	-	453,689	**0.0%**	**Total Net Operating Tax**	1,418,988	-	1,418,988	**0.0%**
8,493	**-**	**8,493**	**0.0%**	**Other income**	**8,618**	**-**	**8,618**	**0.0%**
25,862,473	**(5,684,883)**	**31,547,356**	**554.9%**	**Change in Net Assets**	**41,031,912**	**(30,385,904)**	**71,417,816**	**235.0%**
88.7%	***97.7%***	***9.0%***	***9.3%***	***Medical Loss Ratio***	***94.8%***	***97.9%***	***3.1%***	***3.2%***
3.4%	***4.2%***	***0.8%***	***19.6%***	***Admin Loss Ratio***	***2.9%***	***4.1%***	***1.2%***	***29.2%***

Back to Agenda

MEDI-CAL INCOME STATEMENT– NOVEMBER MONTH:

REVENUES of $318.8 million are favorable to budget $19.5 million driven by:

- Favorable volume related variance of $8.2 million
- Favorable price related variance of $11.3 million
  - $12.0 million of net Proposition 56 revenue due to the extension by the Department of Health Care Services (DHCS) and Proposition 56 risk corridor estimates

MEDICAL EXPENSES of $282.6 million are favorable to budget $9.8 million driven by:

- Unfavorable volume related variance of $8.0 million
- Favorable price related variance of $17.8 million
  - Facilities Claims expense favorable variance of $19.6 million due to Incurred But Not Reported (IBNR) claims due to deferred and delayed services
  - Prescription Drugs expense favorable variance of $3.0 million
  - Medical Management expense favorable variance of $1.3 million
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $1.2 million
  - Professional Claims expense favorable variance of $1.1 million due to deferred and delayed services
  - Offset by Provider Capitation expense unfavorable variance of $7.1 million due to Proposition 56 estimates and short-term supplemental rate increase due to COVID-19
  - Reinsurance & Other expense unfavorable variance of $1.4 million due to COVID-19 vaccination incentives

ADMINISTRATIVE EXPENSES of $10.8 million are favorable to budget $1.8 million driven by:

- Salaries & Benefit expense favorable to budget $1.3 million
- Other Non-Salary expense favorable to budget $0.5 million

NET INVESTMENT & OTHER INCOME

- Unfavorable variance is primarily driven by unrealized losses due to the recent increases in interest rates resulting in lower bond value

CHANGE IN NET ASSETS is $25.9 million for the month, favorable to budget $31.5 million

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

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,877	**15,133**	**(256)**	**(1.7%)**	**Member Months**	**74,034**	**75,291**	**(1,257)**	**(1.7%)**
				Revenues				
2,900,652	2,807,900	92,752	3.3%	Medi-Cal Capitation Revenue	13,879,440	14,044,240	(164,800)	(1.2%)
17,848,402	18,997,482	(1,149,080)	(6.0%)	Medicare Capitation Revenue Part C	93,106,732	95,312,316	(2,205,584)	(2.3%)
5,622,335	5,731,383	(109,048)	(1.9%)	Medicare Capitation Revenue Part D	28,899,255	28,532,310	366,945	1.3%
-	-	-	0.0%	Other Income	-	-	-	0.0%
26,371,390	**27,536,765**	**(1,165,375)**	**(4.2%)**	**Total Operating Revenue**	**135,885,426**	**137,888,866**	**(2,003,440)**	**(1.5%)**
				Medical Expenses				
10,673,793	11,429,474	755,681	6.6%	Provider Capitation	55,123,043	57,353,437	2,230,394	3.9%
3,028,703	4,297,922	1,269,219	29.5%	Facilities Claims	19,684,390	21,493,591	1,809,202	8.4%
1,081,645	1,024,111	(57,534)	(5.6%)	Ancillary	5,543,099	5,168,696	(374,403)	(7.2%)
1,151,630	1,407,995	256,365	18.2%	MLTSS	6,946,855	7,215,093	268,238	3.7%
5,678,433	6,457,990	779,557	12.1%	Prescription Drugs	30,019,632	32,470,559	2,450,927	7.5%
1,035,462	1,235,095	199,633	16.2%	Medical Management	5,135,921	6,128,809	992,888	16.2%
149,395	174,904	25,509	14.6%	Other Medical Expenses	1,046,832	881,363	(165,469)	(18.8%)
22,799,061	**26,027,491**	**3,228,430**	**12.4%**	**Total Medical Expenses**	**123,499,773**	**130,711,548**	**7,211,775**	**5.5%**
3,572,329	**1,509,274**	**2,063,055**	**136.7%**	**Gross Margin**	**12,385,653**	**7,177,318**	**5,208,335**	**72.6%**
				Administrative Expenses				
651,457	879,635	228,178	25.9%	Salaries, Wages & Employee Benefits	3,660,831	4,359,788	698,957	16.0%
50,000	11,750	(38,250)	(325.5%)	Professional Fees	144,581	208,750	64,169	30.7%
102,979	108,609	5,630	5.2%	Purchased Services	487,781	543,045	55,264	10.2%
149,322	138,109	(11,213)	(8.1%)	Printing and Postage	437,992	690,545	252,553	36.6%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
398	21,075	20,677	98.1%	Other Operating Expenses	5,705	105,375	99,671	94.6%
507,123	680,053	172,930	25.4%	Indirect Cost Allocation	2,535,613	3,400,265	864,652	25.4%
1,461,279	**1,839,231**	**377,952**	**20.5%**	**Total Administrative Expenses**	**7,272,503**	**9,307,768**	**2,035,265**	**21.9%**
2,111,050	**(329,957)**	**2,441,007**	**739.8%**	**Change in Net Assets**	**5,113,150**	**(2,130,450)**	**7,243,600**	**340.0%**
86.5%	***94.5%***	***8.1%***	***8.5%***	***Medical Loss Ratio***	***90.9%***	***94.8%***	***3.9%***	***4.1%***
5.5%	***6.7%***	***1.1%***	***17.0%***	***Admin Loss Ratio***	***5.4%***	***6.8%***	***1.4%***	***20.7%***

ONECARE CONNECT INCOME STATEMENT– NOVEMBER MONTH:

REVENUES of $26.4 million are unfavorable to budget $1.2 million driven by:

- Unfavorable volume related variance of $0.5 million
- Unfavorable price related variance of $0.7 million

MEDICAL EXPENSES of $22.8 million are favorable to budget $3.2 million driven by:

- Favorable volume related variance of $0.4 million
- Favorable price related variance of $2.8 million
  - Facilities Claims expense favorable variance of $1.2 million
  - Prescription Drugs expense favorable variance of $0.7 million
  - Provider Capitation expense favorable variance of $0.6 million
  - MLTSS favorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.4 million

CHANGE IN NET ASSETS is $2.1 million, favorable to budget $2.4 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,274	**1,780**	**494**	**27.8%**	**Member Months**	**10,787**	**8,839**	**1,948**	**22.0%**
				Revenues				
1,951,268	1,404,805	546,463	38.9%	Medicare Part C revenue	9,372,878	6,980,945	2,391,933	34.3%
1,130,988	638,276	492,712	77.2%	Medicare Part D revenue	4,943,833	3,176,463	1,767,370	55.6%
3,082,256	**2,043,081**	**1,039,175**	**50.9%**	**Total Operating Revenue**	**14,316,710**	**10,157,408**	**4,159,302**	**40.9%**
				Medical Expenses				
773,249	545,582	(227,667)	(41.7%)	Provider Capitation	3,843,062	2,711,169	(1,131,893)	(41.7%)
928,535	601,625	(326,910)	(54.3%)	Inpatient	4,023,896	2,999,276	(1,024,620)	(34.2%)
52,692	71,062	18,370	25.9%	Ancillary	509,217	358,007	(151,210)	(42.2%)
78,698	28,892	(49,806)	(172.4%)	Skilled Nursing Facilities	373,088	147,104	(225,984)	(153.6%)
915,647	669,476	(246,171)	(36.8%)	Prescription Drugs	4,533,866	3,367,747	(1,166,119)	(34.6%)
28,360	51,717	23,357	45.2%	Medical Management	157,840	251,862	94,022	37.3%
8,250	1,317	(6,933)	(526.4%)	Other Medical Expenses	12,632	6,540	(6,092)	(93.2%)
2,785,431	**1,969,671**	**(815,760)**	**(41.4%)**	**Total Medical Expenses**	**13,453,600**	**9,841,705**	**(3,611,895)**	**(36.7%)**
296,825	**73,410**	**223,415**	**304.3%**	**Gross Margin**	**863,110**	**315,703**	**547,407**	**173.4%**
				Administrative Expenses				
71,471	73,312	1,841	2.5%	Salaries, wages & employee benefits	386,085	365,773	(20,312)	(5.6%)
29,167	29,166	(1)	(0.0%)	Professional fees	152,599	145,830	(6,769)	(4.6%)
10,770	9,167	(1,603)	(17.5%)	Purchased services	54,447	45,835	(8,612)	(18.8%)
33,872	15,823	(18,049)	(114.1%)	Printing and postage	61,100	79,115	18,015	22.8%
205	1,029	824	80.1%	Other operating expenses	410	5,145	4,735	92.0%
50,339	50,924	585	1.1%	Indirect cost allocation, occupancy expens	251,694	254,620	2,926	1.1%
195,823	**179,421**	**(16,402)**	**(9.1%)**	**Total Administrative Expenses**	**906,334**	**896,318**	**(10,016)**	**(1.1%)**
101,002	**(106,011)**	**207,013**	**195.3%**	**Change in Net Assets**	**(43,224)**	**(580,615)**	**537,391**	**92.6%**
90.4%	***96.4%***	***6.0%***	***6.3%***	***Medical Loss Ratio***	***94.0%***	***96.9%***	***2.9%***	***3.0%***
6.4%	***8.8%***	***2.4%***	***27.7%***	***Admin Loss Ratio***	***6.3%***	***8.8%***	***2.5%***	***28.3%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Five Months Ending November 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
415	**404**	**11**	**2.7%**	**Member Months**	**2,050**	**1,993**	**57**	**2.9%**
				Revenues				
2,521,658	2,511,120	10,538	0.4%	Medi-Cal Capitation Revenue	12,557,673	12,387,872	169,801	1.4%
545,630	618,967	(73,337)	(11.8%)	Medicare Part C Revenue	2,936,716	3,045,949	(109,233)	(3.6%)
140,269	147,135	(6,866)	(4.7%)	Medicare Part D Revenue	978,920	726,213	252,707	34.8%
3,207,556	**3,277,222**	**(69,666)**	**(2.1%)**	**Total Operating Revenue**	**16,473,309**	**16,160,034**	**313,275**	**1.9%**
				Medical Expenses				
803,134	1,001,104	197,970	19.8%	Medical Management	4,070,110	4,938,614	868,504	17.6%
708,621	718,052	9,431	1.3%	Facilities Claims	3,738,103	3,601,620	(136,483)	(3.8%)
647,789	652,991	5,202	0.8%	Professional Claims	3,856,599	3,266,259	(590,340)	(18.1%)
121,617	145,053	23,436	16.2%	Patient Transportation	602,823	677,411	74,588	11.0%
281,064	317,999	36,935	11.6%	Prescription Drugs	1,620,870	1,577,852	(43,018)	(2.7%)
9,786	42,701	32,915	77.1%	MLTSS	268,646	190,910	(77,736)	(40.7%)
5,188	4,926	(262)	(5.3%)	Other Expenses	25,625	24,787	(838)	(3.4%)
2,577,199	**2,882,826**	**305,627**	**10.6%**	**Total Medical Expenses**	**14,182,776**	**14,277,453**	**94,677**	**0.7%**
630,358	**394,396**	**235,962**	**59.8%**	**Gross Margin**	**2,290,532**	**1,882,581**	**407,951**	**21.7%**
				Administrative Expenses				
101,085	158,017	56,932	36.0%	Salaries, wages & employee benefits	565,061	746,006	180,945	24.3%
-	167	167	100.0%	Professional fees	5,716	835	(4,881)	(584.6%)
624	40,925	40,301	98.5%	Purchased services	40,457	204,625	164,168	80.2%
11	19,238	19,227	99.9%	Printing and postage	51,700	96,190	44,490	46.3%
346	400	54	13.4%	Depreciation & amortization	5,701	2,000	(3,701)	(185.0%)
4,440	4,309	(131)	(3.0%)	Other operating expenses	35,967	21,545	(14,422)	(66.9%)
9,018	4,944	(4,074)	(82.4%)	Indirect Cost Allocation, Occupancy Expense	44,650	24,720	(19,930)	(80.6%)
115,523	**228,000**	**112,477**	**49.3%**	**Total Administrative Expenses**	**749,252**	**1,095,921**	**346,669**	**31.6%**
				Operating Tax				
6,159	-	6,159	0.0%	Tax Revenue	30,422	-	30,422	0.0%
6,159	-	(6,159)	0.0%	Premium Tax Expense	30,422	-	(30,422)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
514,834	**166,396**	**348,438**	**209.4%**	**Change in Net Assets**	**1,541,281**	**786,660**	**754,621**	**95.9%**
80.3%	***88.0%***	***7.6%***	***8.7%***	***Medical Loss Ratio***	***86.1%***	***88.4%***	***2.3%***	***2.6%***
3.6%	***7.0%***	***3.4%***	***48.2%***	***Admin Loss Ratio***	***4.5%***	***6.8%***	***2.2%***	***32.9%***

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

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
37,599	54,250	16,651	30.7%	Purchase services	187,056	271,250	84,194	31.0%
172,071	206,000	33,929	16.5%	Depreciation & amortization	862,540	1,030,000	167,460	16.3%
19,565	19,750	185	0.9%	Insurance expense	97,824	98,750	926	0.9%
115,086	131,583	16,497	12.5%	Repair and maintenance	516,430	657,915	141,485	21.5%
28,443	43,000	14,557	33.9%	Other Operating Expense	291,763	215,000	(76,763)	(35.7%)
(372,763)	(454,583)	(81,820)	(18.0%)	Indirect allocation, Occupancy	(1,955,613)	(2,272,915)	(317,302)	(14.0%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

OTHER INCOME STATEMENTS – NOVEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $0.2 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.5 million, favorable to budget $0.3 million

CalOptima
Balance Sheet
November 30, 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$152,611,818	Accounts Payable	$34,216,093
Short-term Investments	975,083,742	Medical Claims liability	817,052,780
Capitation receivable	553,976,291	Accrued Payroll Liabilities	14,560,755
Receivables - Other	60,596,590	Deferred Revenue	9,479,216
Prepaid expenses	11,198,154	Deferred Lease Obligations	124,462
		Capitation and Withholds	161,113,436
Total Current Assets	**1,753,466,595**	**Total Current Liabilities**	**1,036,546,741**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	7,084,715		
505 City Parkway West	51,777,223		
	105,113,023		
Less: accumulated depreciation	(60,506,042)		
Capital assets, net	44,606,981	Other (than pensions) post employment benefits liability	31,825,622
Other Assets		Net Pension Liabilities	30,225,137
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,098,597,501**
Cash and Cash Equivalents	3,062,594		
Investments	584,284,668	**Deferred Inflows**	
Total Board-designated Assets	587,347,262	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	644,446,175	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,442,519,751**	TNE	107,228,877
Deferred Outflows		Funds in Excess of TNE	1,247,322,528
Contributions	1,508,025	**TOTAL NET POSITION**	1,354,551,405
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,457,512,048**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,457,512,048**

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

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	240,598,181				
	Tier 1 - MetLife	239,540,029				
Board-designated Reserve		480,138,210	377,163,624	584,760,411	102,974,586	(104,622,201)
	Tier 2 - Payden & Rygel	53,618,197				
	Tier 2 - MetLife	53,590,854				
TNE Requirement		107,209,051	107,228,877	107,228,877	(19,826)	(19,826)
	Consolidated:	**587,347,262**	**484,392,502**	**691,989,288**	**102,954,760**	**(104,642,026)**
	Current reserve level	*1.70*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
November 30, 2021

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	27,838,192	45,770,612
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	534,547	2,820,068
Changes in assets and liabilities:		
Prepaid expenses and other	3,800,658	780,457
Catastrophic reserves		
Capitation receivable	(346,121,067)	(139,676,863)
Medical claims liability	8,672,960	(127,266,168)
Deferred revenue	(4,800)	(4,107,610)
Payable to health networks	(23,354,767)	16,333,647
Accounts payable	14,423,920	(12,198,328)
Accrued payroll	(1,190,413)	(1,835,411)
Other accrued liabilities	-	(2,867)
Net cash provided by/(used in) operating activities	(315,400,769)	(219,382,461)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	217,594,672	90,326,065
Change in Property and Equipment	(553,888)	(1,699,174)
Change in Board designated reserves	403,558	1,532,890
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	217,444,342	90,159,781
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(97,956,427)	(129,222,681)
CASH AND CASH EQUIVALENTS, beginning of period	$250,568,244	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**152,611,818**	**152,611,818**

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BALANCE SHEET – NOVEMBER MONTH:

ASSETS of $2.5 billion increased $26.4 million from October or 1.1%

- Capitation Receivables increased $344.8 million due to the timing of cash receipts
- Operating Cash and Short-term Investments net decrease of $315.6 million due a delay of the state's November capitation payment
  - Short-term Investments decreased $217.6 million
  - Operating cash decreased $98.0 million

LIABILITIES of $1.1 billion decreased $1.5 million from October or 0.1%

- Capitation and Withhold decreased $23.4 million due to timing of capitation payments
- Accounts Payable increased $14.4 million due to the timing of accruals for the quarterly premium tax payment
- Claims Liabilities increased $8.7 million due to timing of claim payments and changes in IBNR

NET ASSETS of $1.4 billion, increased $27.8 million from October or 2.1%

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

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

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

This report only lists Board approved projects.

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

Budget Allocation Changes
Reporting Changes for November 2021

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

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

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Financial Summary

December 31, 2021

February 3, 2022

Board of Directors Meeting

Nancy Huang, Chief Financial Officer

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Financial Highlights: December 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
870,489	844,653	25,836	3.1%	Member Months	5,154,977	5,052,263	102,714	2.0%
391,870,442	332,182,523	59,687,919	18.0%	Revenues	2,303,834,138	1,987,774,426	316,059,712	15.9%
348,842,590	331,169,788	(17,672,802)	(5.3%)	Medical Expenses	2,155,081,243	1,946,686,324	(208,394,919)	(10.7%)
13,235,448	15,432,756	2,197,308	14.2%	Administrative Expenses	72,744,979	87,818,432	15,073,453	17.2%
29,792,404	**(14,420,021)**	**44,212,425**	**306.6%**	**Operating Margin**	**76,007,917**	**(46,730,330)**	**122,738,247**	**262.7%**
(250,152)	833,334	(1,083,486)	(130.0%)	Non Operating Income (Loss)	(695,053)	5,000,000	(5,695,053)	(113.9%)
29,542,252	**(13,586,687)**	**43,128,939**	**317.4%**	**Change in Net Assets**	**75,312,864**	**(41,730,330)**	**117,043,194**	**280.5%**
89.0%	99.7%	10.7%		Medical Loss Ratio	93.5%	97.9%	4.4%	
3.4%	4.6%	1.3%		Administrative Loss Ratio	3.2%	4.4%	1.3%	
7.6%	(4.3%)	11.9%		Operating Margin Ratio	3.3%	(2.4%)	5.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.0%	99.7%	10.7%		*MLR (excluding Directed Payments)	93.1%	97.9%	4.8%	
3.4%	4.6%	1.3%		*ALR (excluding Directed Payments)	3.4%	4.4%	1.1%	

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

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Performance Snapshot: December 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
29.2	(13.5)	42.6	Medi-Cal	68.8	(43.9)	112.6
(0.2)	(0.9)	0.7	OCC	4.9	(3.0)	7.9
(0.3)	(0.1)	(0.1)	OneCare	(0.3)	(0.7)	0.4
1.1	0.1	1.0	PACE	2.6	0.9	1.8
29.8	**(14.4)**	**44.2**	**Operating**	**76.0**	**(46.7)**	**122.7**
(0.3)	0.8	(1.1)	Inv./Rental Inc, MCO tax	(0.7)	5.0	(5.7)
(0.3)	**0.8**	**(1.1)**	**Non-Operating**	**(0.7)**	**5.0**	**(5.7)**
29.5	**(13.6)**	**43.1**	**TOTAL**	**75.3**	**(41.7)**	**117.0**

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD (Dec 2021): $29.5 million, favorable to budget $43.1 million or 317.4%, primarily due to Intergovernmental Transfer (IGT) 10 revenue and deferred and delayed services
  - YTD (Jul – Dec 2021): $75.3 million, favorable to budget $117.0 million or 280.5%
- Enrollment
  - MTD: 870,489 members, favorable to budget 25,836 or 3.1%
  - YTD: 5,154,977 members, favorable to budget 102,714 or 2.0%
- Revenue
  - MTD: $391.9 million, favorable to budget $59.7 million or 18.0% driven by Medi-Cal (MC) line of business (LOB):
    - $21.7 million of net Proposition 56 revenue due to the extension by the Department of Health Care Services (DHCS) and Proposition 56 risk corridor estimates
    - $18.4 million of IGT 10 revenue
    - $9.2 million due to favorable enrollment
  - YTD: $2.3 billion, favorable to budget $316.1 million or 15.9% driven by MC LOB:
    - $132.6 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP)
    - $88.6 million due to the extension of Proposition 56 and updates to the Proposition 56 risk corridor
    - $26.6 million increase in Long-Term Care (LTC), pharmacy funding from DHCS, and Coordinated Care Initiative (CCI)
    - $18.4 million of IGT 10 revenue
    - $36.8 million due to favorable enrollment

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $348.8 million, unfavorable to budget $17.7 million or 5.3% driven by MC LOB:
    - Provider Capitation expense unfavorable variance of $27.3 million due to Proposition 56 estimates and short-term supplemental rate increase due to COVID-19
    - Reinsurance & Other expense unfavorable variance of $2.5 million
    - Favorable variance of $11.8 million in all other medical expense categories due to deferred and delayed services
  - YTD: $2.2 billion, unfavorable to budget $208.4 million or 10.7% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $143.1 million due to FY 2020 DP
    - Provider Capitation expense unfavorable variance of $101.6 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
- Administrative Expenses
  - MTD: $13.2 million, favorable to budget $2.2 million or 14.2%
  - YTD: $72.7 million, favorable to budget $15.1 million or 17.2%
- Net Investment & Other Income
  - MTD: ($0.3) million, unfavorable to budget $1.1 million or 130.0%
  - YTD: ($0.7) million, unfavorable to budget $5.7 million or 113.9%
    - Unfavorable variance is primarily driven by unrealized losses due to the recent increases in interest rates resulting in lower bond value

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 89.0%, Budget 99.7%
  - YTD: Actual 93.5% (93.1% excluding DP), Budget 97.9%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.4% , Budget 4.6%
  - YTD: Actual 3.2% (3.4% excluding DP), Budget 4.4%
- Balance Sheet Ratios
  - *Current ratio: 1.72
  - Board-designated reserve funds level: 1.69
  - Net position: $1.4 billion, including required Tangible Net Equity (TNE) of $108.2 million

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

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Enrollment Summary: December 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
119,060	117,411	1,649	1.4%	SPD	711,126	702,914	8,212	1.2%
300,609	297,173	3,436	1.2%	TANF Child	1,797,893	1,781,262	16,631	0.9%
114,548	107,339	7,209	6.7%	TANF Adult	668,388	640,791	27,597	4.3%
3,204	3,191	13	0.4%	LTC	18,864	19,146	(282)	(1.5%)
303,592	291,028	12,564	4.3%	MCE	1,783,196	1,737,721	45,475	2.6%
11,792	11,159	633	5.7%	WCM	70,955	66,954	4,001	6.0%
852,805	**827,301**	**25,504**	**3.1%**	**Medi-Cal Total**	**5,050,422**	**4,948,788**	**101,634**	**2.1%**
14,933	**15,160**	**(227)**	**(1.5%)**	**OneCare Connect**	**88,967**	**90,451**	**(1,484)**	**(1.6%)**
2,330	**1,785**	**545**	**30.5%**	**OneCare**	**13,117**	**10,624**	**2,493**	**23.5%**
421	**407**	**14**	**3.4%**	**PACE**	**2,471**	**2,400**	**71**	**3.0%**
870,489	**844,653**	**25,836**	**3.1%**	**CalOptima Total**	**5,154,977**	**5,052,263**	**102,714**	**2.0%**

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Consolidated Revenue & Expenses: December 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	537,421	303,592	11,792	852,805	14,933	2,330	421	870,489
REVENUES								
Capitation Revenue	179,918,642	$ 151,739,461	$ 26,298,741	$ 357,956,844	$ 27,460,143	$ 2,978,435	$ 3,475,020	$ 391,870,442
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	179,918,642	151,739,461	26,298,741	357,956,844	27,460,143	2,978,435	3,475,020	391,870,442
MEDICAL EXPENSES								
Provider Capitation	54,879,026	54,121,024	8,973,044	117,973,095	10,492,616	789,657		129,255,368
Facilities	28,545,941	30,955,930	2,399,022	61,900,892	4,224,191	1,122,233	351,700	67,599,016
Professional Claims	18,009,632	9,693,280	1,390,014	29,092,925	1,183,635	97,333	585,844	30,959,737
Prescription Drugs	21,700,064	28,498,172	7,920,513	58,118,749	7,043,368	955,487	306,881	66,424,484
MLTSS	35,359,358	4,097,730	1,525,944	40,983,032	1,650,544	3,652	64,470	42,701,698
Medical Management	2,455,115	1,462,523	309,902	4,227,540	968,602	42,828	785,687	6,024,657
Quality Incentives	1,287,783	855,406	33,760	2,176,949	234,285		5,263	2,416,496
Reinsurance & Other	1,787,463	1,354,999	9,950	3,152,413	191,610	7,911	109,200	3,461,134
Total Medical Expenses	164,024,382	131,039,064	22,562,150	317,625,595	25,988,851	3,019,100	2,209,045	348,842,590
Medical Loss Ratio	91.2%	86.4%	85.8%	88.7%	94.6%	101.4%	63.6%	89.0%
GROSS MARGIN	**15,894,260**	**20,700,398**	**3,736,592**	**40,331,250**	**1,471,292**	**(40,665)**	**1,265,976**	**43,027,852**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,476,502	739,606	70,322	117,333	8,403,763
Professional fees				344,304	25,000	29,167	181	398,651
Purchased services				1,255,818	103,756	11,196	9,899	1,380,669
Printing & Postage				442,560	34,059	3,663	18,014	498,297
Depreciation & Amortization				356,889			346	357,236
Other expenses				1,884,696	545	205	3,861	1,889,307
Indirect cost allocation & Occupancy				(580,853)	779,583	99,322	9,474	307,526
Total Administrative Expenses				11,179,917	1,682,550	213,873	159,108	13,235,448
Admin Loss Ratio				3.1%	6.1%	7.2%	4.6%	3.4%
INCOME (LOSS) FROM OPERATIONS				29,151,332	(211,257)	(254,539)	1,106,868	29,792,404
INVESTMENT INCOME								(758,444)
TOTAL MCO TAX				508,194				508,194
OTHER INCOME				98				98
CHANGE IN NET ASSETS				**$ 29,659,624**	**$ (211,257)**	**$ (254,539)**	**$ 1,106,868**	**$ 29,542,252**
BUDGETED CHANGE IN NET ASSETS				(13,489,820)	(865,972)	(148,775)	84,546	(13,586,687)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 43,149,444	$ 654,715	$ (105,764)	$ 1,022,322	$ 43,128,939

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Consolidated Revenue & Expenses: December 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,196,271	1,783,196	70,955	5,050,422	88,967	13,117	2,471	5,154,977
REVENUES								
Capitation Revenue	1,074,228,394	$ 877,811,955	$ 151,204,746	$ 2,103,245,096	$ 163,345,569	$ 17,295,145	$ 19,948,329	$ 2,303,834,138
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,074,228,394	877,811,955	151,204,746	2,103,245,096	163,345,569	17,295,145	19,948,329	2,303,834,138
MEDICAL EXPENSES								
Provider Capitation	282,490,656	302,466,514	55,879,151	640,836,321	64,491,649	4,632,718		709,960,688
Facilities	151,763,210	149,628,291	30,726,714	332,118,215	23,908,580	5,146,129	4,089,803	365,262,727
Professional Claims	129,205,806	64,551,478	8,804,745	202,562,029	6,726,734	606,550	4,442,443	214,337,756
Prescription Drugs	130,662,634	175,743,678	40,516,030	346,922,342	37,063,000	5,489,352	1,927,751	391,402,445
MLTSS	225,429,567	24,713,024	11,753,843	261,896,434	8,597,399	376,740	333,116	271,203,690
Medical Management	14,774,954	8,723,526	1,876,044	25,374,525	6,104,524	200,667	4,855,797	36,535,513
Quality Incentives	9,635,316	5,738,566	354,682	15,728,564	1,358,295		30,888	17,117,746
Reinsurance & Other	92,124,939	55,102,341	62,389	147,289,669	1,238,442	20,544	712,023	149,260,677
Total Medical Expenses	1,036,087,082	786,667,418	149,973,599	1,972,728,099	149,488,623	16,472,700	16,391,821	2,155,081,243
Medical Loss Ratio	96.4%	89.6%	99.2%	93.8%	91.5%	95.2%	82.2%	93.5%
GROSS MARGIN	**38,141,312**	**91,144,537**	**1,231,148**	**130,516,997**	**13,856,945**	**822,445**	**3,556,508**	**148,752,895**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				42,306,226	4,400,437	456,407	682,395	47,845,465
Professional fees				1,303,641	169,581	181,765	5,897	1,660,884
Purchased services				5,934,427	591,537	65,642	50,356	6,641,962
Printing & Postage				1,909,861	472,051	64,763	69,714	2,516,388
Depreciation & Amortization				2,308,717			6,047	2,314,764
Other expenses				9,420,406	6,250	615	39,827	9,467,098
Indirect cost allocation & Occupancy				(1,421,918)	3,315,196	351,015	54,124	2,298,417
Total Administrative Expenses				61,761,359	8,955,053	1,120,208	908,359	72,744,979
Admin Loss Ratio				2.9%	5.5%	6.5%	4.6%	3.2%
INCOME (LOSS) FROM OPERATIONS				68,755,638	4,901,892	(297,763)	2,648,149	76,007,917
INVESTMENT INCOME								(2,630,951)
TOTAL MCO TAX				1,927,182				1,927,182
OTHER INCOME				8,716				8,716
CHANGE IN NET ASSETS				**$ 70,691,536**	**$ 4,901,892**	**$ (297,763)**	**$ 2,648,149**	**$ 75,312,864**
BUDGETED CHANGE IN NET ASSETS				(43,875,724)	(2,996,422)	(729,390)	871,206	(41,730,330)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 114,567,260	$ 7,898,314	$ 431,627	$ 1,776,943	$ 117,043,194

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Balance Sheet: As of December 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$550,438,140	Accounts Payable	$49,206,144
Short-term Investments	955,481,443	Medical Claims liability	793,053,569
Capitation receivable	205,691,498	Accrued Payroll Liabilities	15,138,741
Receivables - Other	64,658,203	Deferred Revenue	9,510,510
Prepaid expenses	12,295,138	Deferred Lease Obligations	124,462
		Capitation and Withholds	174,250,544
Total Current Assets	**1,788,564,422**	**Total Current Liabilities**	**1,041,283,972**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	7,606,244		
505 City Parkway West	51,777,223		
	105,634,552		
Less: accumulated depreciation	(61,038,837)		
Capital assets, net	44,595,715	Other (than pensions) post employment benefits liability	31,886,443
Other Assets		Net Pension Liabilities	30,345,020
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,103,515,435**
Cash and Cash Equivalents	2,231,505		
Investments	584,489,382	**Deferred Inflows**	
Total Board-designated Assets	586,720,887	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	643,819,800	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,476,979,937**	TNE	108,177,918
		Funds in Excess of TNE	1,275,915,739
Deferred Outflows		**TOTAL NET POSITION**	1,384,093,657
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,491,972,234**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,491,972,234**

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Board Designated Reserve and TNE Analysis: As of December 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	240,328,307				
	Tier 1 - MetLife	239,324,316				
Board-designated Reserve		479,652,624	378,748,226	587,430,859	100,904,398	(107,778,235)
	Tier 2 - Payden & Rygel	53,554,523				
	Tier 2 - MetLife	53,513,740				
TNE Requirement		107,068,263	108,177,918	108,177,918	(1,109,655)	(1,109,655)
	Consolidated:	**586,720,887**	**486,926,144**	**695,608,777**	**99,794,743**	**(108,887,890)**
	Current reserve level	*1.69*	*1.40*	*2.00*		

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Our Mission

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

CalOptima
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UNAUDITED FINANCIAL STATEMENTS

December 2021

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CalOptima - Consolidated
Financial Highlights
For the Six Months Ended December 31, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
870,489	844,653	25,836	3.1%	Member Months	5,154,977	5,052,263	102,714	2.0%
391,870,442	332,182,523	59,687,919	18.0%	Revenues	2,303,834,138	1,987,774,426	316,059,712	15.9%
348,842,590	331,169,788	(17,672,802)	(5.3%)	Medical Expenses	2,155,081,243	1,946,686,324	(208,394,919)	(10.7%)
13,235,448	15,432,756	2,197,308	14.2%	Administrative Expenses	72,744,979	87,818,432	15,073,453	17.2%
29,792,404	**(14,420,021)**	**44,212,425**	**306.6%**	**Operating Margin**	**76,007,917**	**(46,730,330)**	**122,738,247**	**262.7%**
(250,152)	833,334	(1,083,486)	(130.0%)	Non Operating Income (Loss)	(695,053)	5,000,000	(5,695,053)	(113.9%)
29,542,252	**(13,586,687)**	**43,128,939**	**317.4%**	**Change in Net Assets**	**75,312,864**	**(41,730,330)**	**117,043,194**	**280.5%**
89.0%	99.7%	10.7%		Medical Loss Ratio	93.5%	97.9%	4.4%	
3.4%	4.6%	1.3%		Administrative Loss Ratio	3.2%	4.4%	1.3%	
7.6%	(4.3%)	11.9%		Operating Margin Ratio	3.3%	(2.4%)	5.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.0%	99.7%	10.7%		*MLR (excluding Directed Payments)	93.1%	97.9%	4.8%	
3.4%	4.6%	1.3%		*ALR (excluding Directed Payments)	3.4%	4.4%	1.1%	

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

CalOptima
Financial Dashboard
For the Six Months Ended December 31, 2021

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	852,805	827,301	25,504	3.1%
OneCare Connect	14,933	15,160	(227)	(1.5%)
OneCare	2,330	1,785	545	30.5%
PACE	421	407	14	3.4%
Total	870,489	844,653	25,836	3.1%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 29,660	$ (13,490)	$ 43,150	319.9%
OneCare Connect	(211)	(866)	655	75.6%
OneCare	(255)	(149)	(106)	(71.1%)
PACE	1,107	85	1,022	1202.4%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	(758)	833	(1,591)	(191.0%)
Total	$ 29,543	$ (13,587)	$ 43,130	317.4%

MLR

	Actual	Budget	% Point Var
Medi-Cal	88.7%	100.1%	11.4
OneCare Connect	94.6%	96.3%	1.6
OneCare	101.4%	98.4%	(2.9)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 11,180	$ 13,116	$ 1,936	14.8%
OneCare Connect	1,683	1,891	208	11.0%
OneCare	214	181	(33)	(18.3%)
PACE	159	245	86	35.1%
Total	$ 13,235	$ 15,433	$ 2,197	14.2%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,098	1,221	123
OneCare Connect	182	210	28
OneCare	10	9	(1)
PACE	92	115	23
Total	1,381	1,554	173

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	777	678	99
OneCare Connect	82	72	10
OneCare	229	192	37
PACE	5	4	1
Total	1,093	945	147

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	5,050,422	4,948,788	101,634	2.1%
OneCare Connect	88,967	90,451	(1,484)	(1.6%)
OneCare	13,117	10,624	2,493	23.5%
PACE	2,471	2,400	71	3.0%
Total	5,154,977	5,052,263	102,714	2.0%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 70,692	$ (43,876)	$ 114,568	261.1%
OneCare Connect	4,902	(2,996)	7,898	263.6%
OneCare	(298)	(729)	431	59.1%
PACE	2,648	871	1,777	204.0%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	(2,631)	5,000	(7,631)	(152.6%)
Total	$ 75,313	$ (41,730)	$ 117,043	280.5%

MLR

	Actual	Budget	% Point Var
Medi-Cal	93.8%	98.3%	4.5
OneCare Connect	91.5%	95.0%	3.5
OneCare	95.2%	97.2%	1.9

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 61,761	$ 74,201	$ 12,440	16.8%
OneCare Connect	8,955	11,199	2,244	20.0%
OneCare	1,120	1,077	(43)	(4.0%)
PACE	908	1,341	433	32.3%
Total	$ 72,745	$ 87,818	$ 15,073	17.2%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	6,484	7,306	822
OneCare Connect	1,136	1,257	120
OneCare	59	56	(4)
PACE	551	678	127
Total	8,231	9,296	1,065

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	779	677	102
OneCare Connect	78	72	6
OneCare	221	190	30
PACE	4	4	1
Total	1,082	943	139

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended December 31, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	870,489		844,653		25,836	
REVENUE						
Medi-Cal	$ 357,956,844	$ 419.74	$ 299,332,182	$ 361.82	$ 58,624,662	$ 57.92
OneCare Connect	27,460,143	1,838.89	27,500,901	1,814.04	(40,758)	24.85
OneCare	2,978,435	1,278.30	2,047,152	1,146.86	931,283	131.44
PACE	3,475,020	8,254.20	3,302,288	8,113.73	172,732	140.47
Total Operating Revenue	391,870,442	450.17	332,182,523	393.28	59,687,919	56.89
MEDICAL EXPENSES						
Medi-Cal	317,625,595	372.45	299,706,383	362.27	(17,919,212)	(10.18)
OneCare Connect	25,988,851	1,740.36	26,475,908	1,746.43	487,057	6.07
OneCare	3,019,100	1,295.75	2,015,102	1,128.91	(1,003,998)	(166.84)
PACE	2,209,045	5,247.14	2,972,395	7,303.18	763,350	2,056.04
Total Medical Expenses	348,842,590	400.74	331,169,788	392.08	(17,672,802)	(8.66)
GROSS MARGIN	43,027,852	49.43	1,012,735	1.20	42,015,117	48.23
ADMINISTRATIVE EXPENSES						
Salaries and benefits	8,403,763	9.65	9,729,851	11.52	1,326,088	1.87
Professional fees	398,651	0.46	785,396	0.93	386,745	0.47
Purchased services	1,380,669	1.59	1,363,705	1.61	(16,964)	0.02
Printing & Postage	498,297	0.57	556,998	0.66	58,701	0.09
Depreciation & Amortization	357,236	0.41	492,900	0.58	135,664	0.17
Other expenses	1,889,307	2.17	2,064,972	2.44	175,665	0.27
Indirect cost allocation & Occupancy expense	307,526	0.35	438,934	0.52	131,408	0.17
Total Administrative Expenses	13,235,448	15.20	15,432,756	18.27	2,197,308	3.07
INCOME (LOSS) FROM OPERATIONS	29,792,404	34.22	(14,420,021)	(17.07)	44,212,425	51.29
INVESTMENT INCOME						
Interest income	622,051	0.71	833,334	0.99	(211,283)	(0.28)
Realized gain/(loss) on investments	(90,086)	(0.10)	-	-	(90,086)	(0.10)
Unrealized gain/(loss) on investments	(1,290,409)	(1.48)	-	-	(1,290,409)	(1.48)
Total Investment Income	(758,444)	(0.87)	833,334	0.99	(1,591,778)	(1.86)
TOTAL MCO TAX	508,194	0.58	-	-	508,194	0.58
OTHER INCOME	98	-	-	-	98	-
CHANGE IN NET ASSETS	**29,542,252**	**33.94**	**(13,586,687)**	**(16.09)**	**43,128,939**	**50.03**
MEDICAL LOSS RATIO	**89.0%**		**99.7%**		**10.7%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.6%**		**1.3%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	5,154,977		5,052,263		102,714	
REVENUE						
Medi-Cal	$ 2,103,245,096	$ 416.45	$ 1,790,717,777	$ 361.85	$ 312,527,319	$ 54.60
OneCare Connect	163,345,569	1,836.02	165,389,767	1,828.50	(2,044,198)	7.52
OneCare	17,295,145	1,318.53	12,204,560	1,148.77	5,090,585	169.76
PACE	19,948,329	8,072.98	19,462,322	8,109.30	486,007	(36.32)
Total Operating Revenue	2,303,834,138	446.91	1,987,774,426	393.44	316,059,712	53.47
MEDICAL EXPENSES						
Medi-Cal	1,972,728,099	390.61	1,760,392,213	355.72	(212,335,886)	(34.89)
OneCare Connect	149,488,623	1,680.27	157,187,456	1,737.82	7,698,833	57.55
OneCare	16,472,700	1,255.83	11,856,807	1,116.04	(4,615,893)	(139.79)
PACE	16,391,821	6,633.68	17,249,848	7,187.44	858,027	553.76
Total Medical Expenses	2,155,081,243	418.06	1,946,686,324	385.31	(208,394,919)	(32.75)
GROSS MARGIN	148,752,895	28.85	41,088,102	8.13	107,664,793	20.72
ADMINISTRATIVE EXPENSES						
Salaries and benefits	47,845,465	9.28	55,965,766	11.08	8,120,301	1.80
Professional fees	1,660,884	0.32	3,978,888	0.79	2,318,004	0.47
Purchased services	6,641,962	1.29	7,920,769	1.57	1,278,807	0.28
Printing & Postage	2,516,388	0.49	3,341,988	0.66	825,600	0.17
Depreciation & Amortization	2,314,764	0.45	2,957,400	0.59	642,636	0.14
Other expenses	9,467,098	1.84	11,020,017	2.18	1,552,919	0.34
Indirect cost allocation & Occupancy expense	2,298,417	0.45	2,633,604	0.52	335,187	0.07
Total Administrative Expenses	72,744,979	14.11	87,818,432	17.38	15,073,453	3.27
INCOME (LOSS) FROM OPERATIONS	76,007,917	14.74	(46,730,330)	(9.25)	122,738,247	23.99
INVESTMENT INCOME						
Interest income	3,685,849	0.72	5,000,000	0.99	(1,314,151)	(0.27)
Realized gain/(loss) on investments	203,922	0.04	-	-	203,922	0.04
Unrealized gain/(loss) on investments	(6,520,722)	(1.26)	-	-	(6,520,722)	(1.26)
Total Investment Income	(2,630,951)	(0.51)	5,000,000	0.99	(7,630,951)	(1.50)
TOTAL MCO TAX	1,927,182	0.37	-	-	1,927,182	0.37
OTHER INCOME	8,716	-	-	-	8,716	-
CHANGE IN NET ASSETS	**75,312,864**	**14.61**	**(41,730,330)**	**(8.26)**	**117,043,194**	**22.87**
MEDICAL LOSS RATIO	**93.5%**		**97.9%**		**4.4%**	
ADMINISTRATIVE LOSS RATIO	**3.2%**		**4.4%**		**1.3%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended December 31, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	537,421	303,592	11,792	852,805	14,933	2,330	421	870,489
REVENUES								
Capitation Revenue	179,918,642	$ 151,739,461	$ 26,298,741	$ 357,956,844	$ 27,460,143	$ 2,978,435	$ 3,475,020	$ 391,870,442
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	179,918,642	151,739,461	26,298,741	357,956,844	27,460,143	2,978,435	3,475,020	391,870,442
MEDICAL EXPENSES								
Provider Capitation	54,879,026	54,121,024	8,973,044	117,973,095	10,492,616	789,657		129,255,368
Facilities	28,545,941	30,955,930	2,399,022	61,900,892	4,224,191	1,122,233	351,700	67,599,016
Professional Claims	18,009,632	9,693,280	1,390,014	29,092,925	1,183,635	97,333	585,844	30,959,737
Prescription Drugs	21,700,064	28,498,172	7,920,513	58,118,749	7,043,368	955,487	306,881	66,424,484
MLTSS	35,359,358	4,097,730	1,525,944	40,983,032	1,650,544	3,652	64,470	42,701,698
Medical Management	2,455,115	1,462,523	309,902	4,227,540	968,602	42,828	785,687	6,024,657
Quality Incentives	1,287,783	855,406	33,760	2,176,949	234,285		5,263	2,416,496
Reinsurance & Other	1,787,463	1,354,999	9,950	3,152,413	191,610	7,911	109,200	3,461,134
Total Medical Expenses	164,024,382	131,039,064	22,562,150	317,625,595	25,988,851	3,019,100	2,209,045	348,842,590
Medical Loss Ratio	91.2%	86.4%	85.8%	88.7%	94.6%	101.4%	63.6%	89.0%
GROSS MARGIN	**15,894,260**	**20,700,398**	**3,736,592**	**40,331,250**	**1,471,292**	**(40,665)**	**1,265,976**	**43,027,852**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,476,502	739,606	70,322	117,333	8,403,763
Professional fees				344,304	25,000	29,167	181	398,651
Purchased services				1,255,818	103,756	11,196	9,899	1,380,669
Printing & Postage				442,560	34,059	3,663	18,014	498,297
Depreciation & Amortization				356,889			346	357,236
Other expenses				1,884,696	545	205	3,861	1,889,307
Indirect cost allocation & Occupancy				(580,853)	779,583	99,322	9,474	307,526
Total Administrative Expenses				11,179,917	1,682,550	213,873	159,108	13,235,448
Admin Loss Ratio				3.1%	6.1%	7.2%	4.6%	3.4%
INCOME (LOSS) FROM OPERATIONS				29,151,332	(211,257)	(254,539)	1,106,868	29,792,404
INVESTMENT INCOME								(758,444)
TOTAL MCO TAX				508,194				508,194
OTHER INCOME				98				98
CHANGE IN NET ASSETS				**$ 29,659,624**	**$ (211,257)**	**$ (254,539)**	**$ 1,106,868**	**$ 29,542,252**
BUDGETED CHANGE IN NET ASSETS				(13,489,820)	(865,972)	(148,775)	84,546	(13,586,687)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 43,149,444	$ 654,715	$ (105,764)	$ 1,022,322	$ 43,128,939

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Six Months Ended December 31, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,196,271	1,783,196	70,955	5,050,422	88,967	13,117	2,471	5,154,977
REVENUES								
Capitation Revenue	1,074,228,394	$ 877,811,955	$ 151,204,746	$ 2,103,245,096	$ 163,345,569	$ 17,295,145	$ 19,948,329	$ 2,303,834,138
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,074,228,394	877,811,955	151,204,746	2,103,245,096	163,345,569	17,295,145	19,948,329	2,303,834,138
MEDICAL EXPENSES								
Provider Capitation	282,490,656	302,466,514	55,879,151	640,836,321	64,491,649	4,632,718		709,960,688
Facilities	151,763,210	149,628,291	30,726,714	332,118,215	23,908,580	5,146,129	4,089,803	365,262,727
Professional Claims	129,205,806	64,551,478	8,804,745	202,562,029	6,726,734	606,550	4,442,443	214,337,756
Prescription Drugs	130,662,634	175,743,678	40,516,030	346,922,342	37,063,000	5,489,352	1,927,751	391,402,445
MLTSS	225,429,567	24,713,024	11,753,843	261,896,434	8,597,399	376,740	333,116	271,203,690
Medical Management	14,774,954	8,723,526	1,876,044	25,374,525	6,104,524	200,667	4,855,797	36,535,513
Quality Incentives	9,635,316	5,738,566	354,682	15,728,564	1,358,295		30,888	17,117,746
Reinsurance & Other	92,124,939	55,102,341	62,389	147,289,669	1,238,442	20,544	712,023	149,260,677
Total Medical Expenses	1,036,087,082	786,667,418	149,973,599	1,972,728,099	149,488,623	16,472,700	16,391,821	2,155,081,243
Medical Loss Ratio	96.4%	89.6%	99.2%	93.8%	91.5%	95.2%	82.2%	93.5%
GROSS MARGIN	**38,141,312**	**91,144,537**	**1,231,148**	**130,516,997**	**13,856,945**	**822,445**	**3,556,508**	**148,752,895**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				42,306,226	4,400,437	456,407	682,395	47,845,465
Professional fees				1,303,641	169,581	181,765	5,897	1,660,884
Purchased services				5,934,427	591,537	65,642	50,356	6,641,962
Printing & Postage				1,909,861	472,051	64,763	69,714	2,516,388
Depreciation & Amortization				2,308,717			6,047	2,314,764
Other expenses				9,420,406	6,250	615	39,827	9,467,098
Indirect cost allocation & Occupancy				(1,421,918)	3,315,196	351,015	54,124	2,298,417
Total Administrative Expenses				61,761,359	8,955,053	1,120,208	908,359	72,744,979
Admin Loss Ratio				2.9%	5.5%	6.5%	4.6%	3.2%
INCOME (LOSS) FROM OPERATIONS				68,755,638	4,901,892	(297,763)	2,648,149	76,007,917
INVESTMENT INCOME								(2,630,951)
TOTAL MCO TAX				1,927,182				1,927,182
OTHER INCOME				8,716				8,716
CHANGE IN NET ASSETS				**$ 70,691,536**	**$ 4,901,892**	**$ (297,763)**	**$ 2,648,149**	**$ 75,312,864**
BUDGETED CHANGE IN NET ASSETS				(43,875,724)	(2,996,422)	(729,390)	871,206	(41,730,330)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 114,567,260	$ 7,898,314	$ 431,627	$ 1,776,943	$ 117,043,194

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December 31, 2021 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $29.5 million, $43.1 million favorable to budget
- Operating surplus is $29.8 million, with a deficit in non-operating income of $0.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $75.3 million, $117.0 million favorable to budget
- Operating surplus is $76.0 million, with a deficit in non-operating income of $0.7 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
29.2	(13.5)	42.6	Medi-Cal	68.8	(43.9)	112.6
(0.2)	(0.9)	0.7	OCC	4.9	(3.0)	7.9
(0.3)	(0.1)	(0.1)	OneCare	(0.3)	(0.7)	0.4
1.1	0.1	1.0	PACE	2.6	0.9	1.8
29.8	**(14.4)**	**44.2**	**Operating**	**76.0**	**(46.7)**	**122.7**
(0.3)	0.8	(1.1)	Inv./Rental Inc, MCO tax	(0.7)	5.0	(5.7)
(0.3)	**0.8**	**(1.1)**	**Non-Operating**	**(0.7)**	**5.0**	**(5.7)**
29.5	**(13.6)**	**43.1**	**TOTAL**	**75.3**	**(41.7)**	**117.0**

CalOptima - Consolidated
Enrollment Summary
For the Six Months Ended December 31, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
119,060	117,411	1,649	1.4%	SPD	711,126	702,914	8,212	1.2%
300,609	297,173	3,436	1.2%	TANF Child	1,797,893	1,781,262	16,631	0.9%
114,548	107,339	7,209	6.7%	TANF Adult	668,388	640,791	27,597	4.3%
3,204	3,191	13	0.4%	LTC	18,864	19,146	(282)	(1.5%)
303,592	291,028	12,564	4.3%	MCE	1,783,196	1,737,721	45,475	2.6%
11,792	11,159	633	5.7%	WCM	70,955	66,954	4,001	6.0%
852,805	**827,301**	**25,504**	**3.1%**	**Medi-Cal Total**	**5,050,422**	**4,948,788**	**101,634**	**2.1%**
14,933	**15,160**	**(227)**	**(1.5%)**	**OneCare Connect**	**88,967**	**90,451**	**(1,484)**	**(1.6%)**
2,330	**1,785**	**545**	**30.5%**	**OneCare**	**13,117**	**10,624**	**2,493**	**23.5%**
421	**407**	**14**	**3.4%**	**PACE**	**2,471**	**2,400**	**71**	**3.0%**
870,489	**844,653**	**25,836**	**3.1%**	**CalOptima Total**	**5,154,977**	**5,052,263**	**102,714**	**2.0%**
				Enrollment (by Network)				
198,787	192,081	6,706	3.5%	HMO	1,174,974	1,145,758	29,216	2.5%
230,532	227,960	2,572	1.1%	PHC	1,373,270	1,366,481	6,789	0.5%
208,736	203,096	5,640	2.8%	Shared Risk Group	1,235,730	1,217,404	18,326	1.5%
214,750	204,164	10,586	5.2%	Fee for Service	1,266,448	1,219,145	47,303	3.9%
852,805	**827,301**	**25,504**	**3.1%**	**Medi-Cal Total**	**5,050,422**	**4,948,788**	**101,634**	**2.1%**
14,933	**15,160**	**(227)**	**(1.5%)**	**OneCare Connect**	**88,967**	**90,451**	**(1,484)**	**(1.6%)**
2,330	**1,785**	**545**	**30.5%**	**OneCare**	**13,117**	**10,624**	**2,493**	**23.5%**
421	**407**	**14**	**3.4%**	**PACE**	**2,471**	**2,400**	**71**	**3.0%**
870,489	**844,653**	**25,836**	**3.1%**	**CalOptima Total**	**5,154,977**	**5,052,263**	**102,714**	**2.0%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2022

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,759	10,772	10,796	10,750	10,821	10,837							64,735	64,775	(40)
TANF Child	57,684	57,453	57,592	57,944	58,108	58,236							347,017	342,203	4,814
TANF Adult	33,827	34,099	34,339	34,622	35,046	35,411							207,344	198,873	8,471
LTC		1	3	1		1							6		6
MCE	88,797	89,334	90,159	91,017	91,516	92,159							542,982	527,847	15,135
WCM	2,114	2,193	2,177	2,133	2,130	2,143							12,890	12,060	830
Total	**193,181**	**193,852**	**195,066**	**196,467**	**197,621**	**198,787**							**1,174,974**	**1,145,758**	**29,216**
PHCs															
SPD	6,896	6,819	6,942	6,915	6,953	6,926							41,451	42,693	(1,242)
TANF Child	155,214	154,985	155,440	155,771	156,156	156,251							933,817	928,310	5,507
TANF Adult	14,006	14,054	14,197	14,390	14,667	14,851							86,165	82,791	3,374
LTC		2	1			1							4		4
MCE	44,256	44,359	44,580	44,754	44,973	45,241							268,163	271,455	(3,292)
WCM	7,304	7,368	7,236	7,322	7,178	7,262							43,670	41,232	2,438
Total	**227,676**	**227,587**	**228,396**	**229,152**	**229,927**	**230,532**							**1,373,270**	**1,366,481**	**6,789**
Shared Risk Groups															
SPD	10,063	10,104	10,074	10,003	10,122	10,095							60,461	61,956	(1,495)
TANF Child	59,085	58,837	58,641	58,541	58,523	58,347							351,974	357,424	(5,450)
TANF Adult	33,013	33,123	33,374	33,745	34,109	34,482							201,846	198,737	3,109
LTC	1	1	1		1								4		4
MCE	99,994	100,643	101,666	102,780	103,620	104,418							613,121	590,791	22,330
WCM	1,373	1,368	1,394	1,400	1,395	1,394							8,324	8,496	(172)
Total	**203,529**	**204,076**	**205,150**	**206,469**	**207,770**	**208,736**							**1,235,730**	**1,217,404**	**18,326**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139	80,438	80,738	80,494							481,755	471,300	10,455
TANF Child	1	1	1	1	1	1							6		6
TANF Adult	1,318	1,351	1,392	1,408	1,435	1,465							8,369	6,972	1,397
LTC	2,788	2,778	2,806	2,847	2,864	2,870							16,953	17,322	(369)
MCE	3,612	3,813	4,013	4,268	4,489	4,889							25,084	15,561	9,523
WCM	16	16	18	20	15	18							103	90	13
Total	**87,564**	**88,076**	**88,369**	**88,982**	**89,542**	**89,737**							**532,270**	**511,245**	**21,025**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616	10,358	10,832	10,708							62,724	62,190	534
TANF Child	26,720	26,952	27,715	28,188	27,730	27,774							165,079	153,325	11,754
TANF Adult	26,224	26,653	27,382	27,916	28,150	28,339							164,664	153,418	11,246
LTC	309	314	305	316	321	332							1,897	1,824	73
MCE	53,947	54,384	55,449	56,467	56,714	56,885							333,846	332,067	1,779
WCM	993	962	999	1,030	1,009	975							5,968	5,076	892
Total	**118,356**	**119,312**	**122,466**	**124,275**	**124,756**	**125,013**							**734,178**	**707,900**	**26,278**
SPD	117,710	117,859	118,567	118,464	119,466	119,060							711,126	702,914	8,212
TANF Child	298,704	298,228	299,389	300,445	300,518	300,609							1,797,893	1,781,262	16,631
TANF Adult	108,388	109,280	110,684	112,081	113,407	114,548							668,388	640,791	27,597
LTC	3,098	3,096	3,116	3,164	3,186	3,204							18,864	19,146	(282)
MCE	290,606	292,533	295,867	299,286	301,312	303,592							1,783,196	1,737,721	45,475
WCM	11,800	11,907	11,824	11,905	11,727	11,792							70,955	66,954	4,001
Total Medi-Cal MM	**830,306**	**832,903**	**839,447**	**845,345**	**849,616**	**852,805**							**5,050,422**	**4,948,788**	**101,634**
OneCare Connect	**14,688**	**14,819**	**14,817**	**14,833**	**14,877**	**14,933**							**88,967**	**90,451**	**(1,484)**
OneCare	**2,019**	**2,110**	**2,152**	**2,232**	**2,274**	**2,330**							**13,117**	**10,624**	**2,493**
PACE	**401**	**407**	**409**	**418**	**415**	**421**							**2,471**	**2,400**	**71**
Grand Total	**847,414**	**850,239**	**856,825**	**862,828**	**867,182**	**870,489**							**5,154,977**	**5,052,263**	**102,714**

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ENROLLMENT:

Overall, December enrollment was 870,489

- Favorable to budget 25,836 or 3.1%
- Increased 3,307 or 0.4% from Prior Month (PM) (November 2021)
- Increased 62,199 or 7.7% from Prior Year (PY) (December 2020)

Medi-Cal enrollment was 852,805

- Favorable to budget 25,504 or 3.1%
  - Medi-Cal Expansion (MCE) favorable 12,564
  - Temporary Assistance for Needy Families (TANF) favorable 10,645
  - Seniors and Persons with Disabilities (SPD) favorable 1,649
  - Whole Child Model (WCM) favorable 633
  - Long-Term Care (LTC) favorable 13
- Increased 3,189 from PM

OneCare Connect enrollment was 14,933

- Unfavorable to budget 227 or 1.5%
- Increased 56 from PM

OneCare enrollment was 2,330

- Favorable to budget 545 or 30.5%
- Increased 56 from PM

PACE enrollment was 421

- Favorable to budget 14 or 3.4%
- Increased 6 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
852,805	**827,301**	**25,504**	**3.1%**	**Member Months**	**5,050,422**	**4,948,788**	**101,634**	**2.1%**
				Revenues				
357,956,844	299,332,182	58,624,662	19.6%	Capitation Revenue	2,103,245,096	1,790,717,777	312,527,319	17.5%
-	-	-	0.0%	Other Income	-	-	-	0.0%
357,956,844	**299,332,182**	**58,624,662**	**19.6%**	**Total Operating Revenue**	**2,103,245,096**	**1,790,717,777**	**312,527,319**	**17.5%**
				Medical Expenses				
120,150,044	92,863,885	(27,286,159)	(29.4%)	Provider Capitation	656,564,885	555,005,594	(101,559,291)	(18.3%)
61,900,892	66,408,722	4,507,830	6.8%	Facilities Claims	332,118,215	382,391,162	50,272,947	13.1%
29,092,925	32,197,631	3,104,706	9.6%	Professional Claims	202,562,029	187,709,684	(14,852,345)	(7.9%)
58,118,749	58,686,457	567,708	1.0%	Prescription Drugs	346,922,342	345,521,586	(1,400,756)	(0.4%)
40,983,032	43,244,446	2,261,414	5.2%	MLTSS	261,896,434	253,578,648	(8,317,786)	(3.3%)
4,227,540	5,604,560	1,377,020	24.6%	Medical Management	25,374,525	31,981,442	6,606,917	20.7%
3,152,413	700,682	(2,451,731)	(349.9%)	Reinsurance & Other	147,289,669	4,204,097	(143,085,572)	(3403.5%)
317,625,595	**299,706,383**	**(17,919,212)**	**(6.0%)**	**Total Medical Expenses**	**1,972,728,099**	**1,760,392,213**	**(212,335,886)**	**(12.1%)**
40,331,250	**(374,201)**	**40,705,451**	**10878.0%**	**Gross Margin**	**130,516,997**	**30,325,564**	**100,191,433**	**330.4%**
				Administrative Expenses				
7,476,502	8,589,972	1,113,470	13.0%	Salaries, Wages & Employee Benefits	42,306,226	49,354,320	7,048,094	14.3%
344,304	726,743	382,439	52.6%	Professional Fees	1,303,641	3,564,820	2,261,179	63.4%
1,255,818	1,193,861	(61,957)	(5.2%)	Purchased Services	5,934,427	6,957,420	1,022,993	14.7%
442,560	383,828	(58,732)	(15.3%)	Printing and Postage	1,909,861	2,302,968	393,107	17.1%
356,889	492,500	135,611	27.5%	Depreciation & Amortization	2,308,717	2,955,000	646,283	21.9%
1,884,696	2,025,702	141,006	7.0%	Other Operating Expenses	9,420,406	10,848,682	1,428,276	13.2%
(580,853)	(296,987)	283,866	95.6%	Indirect Cost Allocation, Occupancy Expense	(1,421,918)	(1,781,922)	(360,004)	(20.2%)
11,179,917	**13,115,619**	**1,935,702**	**14.8%**	**Total Administrative Expenses**	**61,761,359**	**74,201,288**	**12,439,929**	**16.8%**
				Operating Tax				
14,362,361	13,931,743	430,618	3.1%	Tax Revenue	85,052,182	83,337,586	1,714,596	2.1%
13,854,167	13,931,743	77,576	0.6%	Premium Tax Expense	83,125,000	83,337,586	212,586	0.3%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
508,194	-	508,194	**0.0%**	**Total Net Operating Tax**	1,927,182	-	1,927,182	**0.0%**
98	**-**	**98**	**0.0%**	**Other income**	**8,716**	**-**	**8,716**	**0.0%**
29,659,624	**(13,489,820)**	**43,149,444**	**319.9%**	**Change in Net Assets**	**70,691,536**	**(43,875,724)**	**114,567,260**	**261.1%**
88.7%	***100.1%***	***11.4%***	***11.4%***	***Medical Loss Ratio***	***93.8%***	***98.3%***	***4.5%***	***4.6%***
3.1%	***4.4%***	***1.3%***	***28.7%***	***Admin Loss Ratio***	***2.9%***	***4.1%***	***1.2%***	***29.1%***

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MEDI-CAL INCOME STATEMENT– DECEMBER MONTH:

REVENUES of $358.0 million are favorable to budget $58.6 million driven by:

- Favorable volume related variance of $9.2 million
- Favorable price related variance of $49.4 million
  - $21.7 million of net Proposition 56 revenue due to the extension by the Department of Health Care Services (DHCS) and Proposition 56 risk corridor estimates
  - $18.4 million of Intergovernmental Transfer (IGT) 10 revenue
  - $4.0 million due to increase in LTC and pharmacy funding from DHCS in primary and Coordinated Care Initiative (CCI) revenue

MEDICAL EXPENSES of $317.6 million are unfavorable to budget $17.9 million driven by:

- Unfavorable volume related variance of $9.2 million
- Unfavorable price related variance of $8.7 million
  - Provider Capitation expense unfavorable variance of $24.4 million due to Proposition 56 estimates and short-term supplemental rate increase due to COVID-19
  - Reinsurance & Other expense unfavorable variance of $2.4 million due to COVID-19 vaccination incentives
  - Offset by:
    - Facilities Claims expense favorable variance of $6.6 million due to deferred and delayed services
    - Professional Claims expense favorable variance of $4.1 million due to deferred and delayed services offset by supplemental rate increase due to COVID-19
    - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $3.6 million
    - Prescription Drugs expense favorable variance of $2.4 million

ADMINISTRATIVE EXPENSES of $11.2 million are favorable to budget $1.9 million driven by:

- Salaries & Benefit expense favorable to budget $1.1 million
- Other Non-Salary expense favorable to budget $0.8 million

NET INVESTMENT INCOME

- Unfavorable variance of $0.8 million is primarily driven by unrealized losses due to the recent increases in interest rates resulting in lower bond value

CHANGE IN NET ASSETS is $29.7 million, favorable to budget $43.1 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Six Months Ending December 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,933	**15,160**	**(227)**	**(1.5%)**	**Member Months**	**88,967**	**90,451**	**(1,484)**	**(1.6%)**
				Revenues				
2,779,926	2,806,522	(26,596)	(0.9%)	Medi-Cal Capitation Revenue	16,659,366	16,850,762	(191,396)	(1.1%)
17,845,640	18,954,241	(1,108,601)	(5.8%)	Medicare Capitation Revenue Part C	110,952,371	114,266,557	(3,314,186)	(2.9%)
6,834,577	5,740,138	1,094,439	19.1%	Medicare Capitation Revenue Part D	35,733,832	34,272,448	1,461,384	4.3%
-	-	-	0.0%	Other Income	-	-	-	0.0%
27,460,143	**27,500,901**	**(40,758)**	**(0.1%)**	**Total Operating Revenue**	**163,345,569**	**165,389,767**	**(2,044,198)**	**(1.2%)**
				Medical Expenses				
10,726,901	11,403,869	676,968	5.9%	Provider Capitation	65,849,944	68,757,306	2,907,362	4.2%
4,224,191	4,409,199	185,008	4.2%	Facilities Claims	23,908,580	25,902,790	1,994,210	7.7%
1,183,635	1,062,409	(121,226)	(11.4%)	Ancillary	6,726,734	6,231,105	(495,629)	(8.0%)
1,650,544	1,448,912	(201,632)	(13.9%)	MLTSS	8,597,399	8,664,005	66,606	0.8%
7,043,368	6,734,731	(308,637)	(4.6%)	Prescription Drugs	37,063,000	39,205,290	2,142,290	5.5%
968,602	1,235,095	266,493	21.6%	Medical Management	6,104,524	7,363,904	1,259,380	17.1%
191,610	181,693	(9,917)	(5.5%)	Other Medical Expenses	1,238,442	1,063,056	(175,386)	(16.5%)
25,988,851	**26,475,908**	**487,057**	**1.8%**	**Total Medical Expenses**	**149,488,623**	**157,187,456**	**7,698,833**	**4.9%**
1,471,292	**1,024,993**	**446,299**	**43.5%**	**Gross Margin**	**13,856,945**	**8,202,311**	**5,654,634**	**68.9%**
				Administrative Expenses				
739,606	902,656	163,050	18.1%	Salaries, Wages & Employee Benefits	4,400,437	5,262,444	862,007	16.4%
25,000	29,320	4,320	14.7%	Professional Fees	169,581	238,070	68,489	28.8%
103,756	119,752	15,996	13.4%	Purchased Services	591,537	662,797	71,260	10.8%
34,059	138,109	104,050	75.3%	Printing and Postage	472,051	828,654	356,603	43.0%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
545	21,075	20,530	97.4%	Other Operating Expenses	6,250	126,450	120,200	95.1%
779,583	680,053	(99,530)	(14.6%)	Indirect Cost Allocation	3,315,196	4,080,318	765,122	18.8%
1,682,550	**1,890,965**	**208,415**	**11.0%**	**Total Administrative Expenses**	**8,955,053**	**11,198,733**	**2,243,680**	**20.0%**
(211,257)	**(865,972)**	**654,715**	**75.6%**	**Change in Net Assets**	**4,901,892**	**(2,996,422)**	**7,898,314**	**263.6%**
94.6%	***96.3%***	***1.6%***	***1.7%***	***Medical Loss Ratio***	***91.5%***	***95.0%***	***3.5%***	***3.7%***
6.1%	***6.9%***	***0.7%***	***10.9%***	***Admin Loss Ratio***	***5.5%***	***6.8%***	***1.3%***	***19.0%***

ONECARE CONNECT INCOME STATEMENT– DECEMBER MONTH:

REVENUES of $27.5 million are unfavorable to budget $40,758 driven by:

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

MEDICAL EXPENSES of $26.0 million are favorable to budget $0.5 million driven by:

- Favorable volume related variance of $0.4 million
- Favorable price related variance of $0.1 million
  - Provider Capitation expense favorable variance of $0.5 million
  - Offset by:
    - Prescription Drugs expense unfavorable variance of $0.4 million

ADMINISTRATIVE EXPENSES of $1.7 million are favorable to budget $0.2 million

CHANGE IN NET ASSETS is ($0.2) million, favorable to budget $0.7 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,330	**1,785**	**545**	**30.5%**	**Member Months**	**13,117**	**10,624**	**2,493**	**23.5%**
				Revenues				
1,969,568	1,407,983	561,585	39.9%	Medicare Part C revenue	11,342,446	8,388,928	2,953,518	35.2%
1,008,866	639,169	369,697	57.8%	Medicare Part D revenue	5,952,699	3,815,632	2,137,067	56.0%
2,978,435	**2,047,152**	**931,283**	**45.5%**	**Total Operating Revenue**	**17,295,145**	**12,204,560**	**5,090,585**	**41.7%**
				Medical Expenses				
789,657	546,817	(242,840)	(44.4%)	Provider Capitation	4,632,718	3,257,986	(1,374,732)	(42.2%)
1,122,233	613,451	(508,782)	(82.9%)	Inpatient	5,146,129	3,612,727	(1,533,402)	(42.4%)
97,333	73,786	(23,547)	(31.9%)	Ancillary	606,550	431,793	(174,757)	(40.5%)
3,652	29,854	26,202	87.8%	Skilled Nursing Facilities	376,740	176,958	(199,782)	(112.9%)
955,487	697,251	(258,236)	(37.0%)	Prescription Drugs	5,489,352	4,064,998	(1,424,354)	(35.0%)
42,828	52,622	9,794	18.6%	Medical Management	200,667	304,484	103,817	34.1%
7,911	1,321	(6,590)	(498.9%)	Other Medical Expenses	20,544	7,861	(12,683)	(161.3%)
3,019,100	**2,015,102**	**(1,003,998)**	**(49.8%)**	**Total Medical Expenses**	**16,472,700**	**11,856,807**	**(4,615,893)**	**(38.9%)**
(40,665)	**32,050**	**(72,715)**	**(226.9%)**	**Gross Margin**	**822,445**	**347,753**	**474,692**	**136.5%**
				Administrative Expenses				
70,322	74,716	4,394	5.9%	Salaries, wages & employee benefits	456,407	440,489	(15,918)	(3.6%)
29,167	29,166	(1)	(0.0%)	Professional fees	181,765	174,996	(6,769)	(3.9%)
11,196	9,167	(2,029)	(22.1%)	Purchased services	65,642	55,002	(10,640)	(19.3%)
3,663	15,823	12,160	76.9%	Printing and postage	64,763	94,938	30,175	31.8%
205	1,029	824	80.1%	Other operating expenses	615	6,174	5,559	90.0%
99,322	50,924	(48,398)	(95.0%)	Indirect cost allocation, occupancy expense	351,015	305,544	(45,471)	(14.9%)
213,873	**180,825**	**(33,048)**	**(18.3%)**	**Total Administrative Expenses**	**1,120,208**	**1,077,143**	**(43,065)**	**(4.0%)**
(254,539)	**(148,775)**	**(105,764)**	**(71.1%)**	**Change in Net Assets**	**(297,763)**	**(729,390)**	**431,627**	**59.2%**
101.4%	***98.4%***	***(2.9%)***	***(3.0%)***	***Medical Loss Ratio***	***95.2%***	***97.2%***	***1.9%***	***2.0%***
7.2%	***8.8%***	***1.7%***	***18.7%***	***Admin Loss Ratio***	***6.5%***	***8.8%***	***2.3%***	***26.6%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
421	**407**	**14**	**3.4%**	**Member Months**	**2,471**	**2,400**	**71**	**3.0%**
				Revenues				
2,597,578	2,527,684	69,894	2.8%	Medi-Cal Capitation Revenue	15,155,251	14,915,556	239,695	1.6%
630,017	625,985	4,032	0.6%	Medicare Part C Revenue	3,566,733	3,671,934	(105,201)	(2.9%)
247,425	148,619	98,806	66.5%	Medicare Part D Revenue	1,226,344	874,832	351,512	40.2%
3,475,020	**3,302,288**	**172,732**	**5.2%**	**Total Operating Revenue**	**19,948,329**	**19,462,322**	**486,007**	**2.5%**
				Medical Expenses				
785,687	1,008,538	222,851	22.1%	Medical Management	4,855,797	5,947,152	1,091,355	18.4%
351,700	748,630	396,930	53.0%	Facilities Claims	4,089,803	4,350,250	260,447	6.0%
585,844	680,970	95,126	14.0%	Professional Claims	4,442,443	3,947,229	(495,214)	(12.5%)
109,200	151,001	41,801	27.7%	Patient Transportation	712,023	828,412	116,389	14.0%
306,881	333,276	26,395	7.9%	Prescription Drugs	1,927,751	1,911,128	(16,623)	(0.9%)
64,470	44,852	(19,618)	(43.7%)	MLTSS	333,116	235,762	(97,354)	(41.3%)
5,263	5,128	(135)	(2.6%)	Other Expenses	30,888	29,915	(973)	(3.3%)
2,209,045	**2,972,395**	**763,350**	**25.7%**	**Total Medical Expenses**	**16,391,821**	**17,249,848**	**858,027**	**5.0%**
1,265,976	**329,893**	**936,083**	**283.8%**	**Gross Margin**	**3,556,508**	**2,212,474**	**1,344,034**	**60.7%**
				Administrative Expenses				
117,333	162,507	45,174	27.8%	Salaries, wages & employee benefits	682,395	908,513	226,118	24.9%
181	167	(14)	(8.1%)	Professional fees	5,897	1,002	(4,895)	(488.5%)
9,899	40,925	31,026	75.8%	Purchased services	50,356	245,550	195,194	79.5%
18,014	19,238	1,224	6.4%	Printing and postage	69,714	115,428	45,714	39.6%
346	400	54	13.4%	Depreciation & amortization	6,047	2,400	(3,647)	(152.0%)
3,861	17,166	13,305	77.5%	Other operating expenses	39,827	38,711	(1,116)	(2.9%)
9,474	4,944	(4,530)	(91.6%)	Indirect Cost Allocation, Occupancy Expense	54,124	29,664	(24,460)	(82.5%)
159,108	**245,347**	**86,239**	**35.1%**	**Total Administrative Expenses**	**908,359**	**1,341,268**	**432,909**	**32.3%**
				Operating Tax				
6,248	-	6,248	0.0%	Tax Revenue	36,670	-	36,670	0.0%
6,248	-	(6,248)	0.0%	Premium Tax Expense	36,670	-	(36,670)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
1,106,868	**84,546**	**1,022,322**	**1209.2%**	**Change in Net Assets**	**2,648,149**	**871,206**	**1,776,943**	**204.0%**
63.6%	***90.0%***	***26.4%***	***29.4%***	***Medical Loss Ratio***	***82.2%***	***88.6%***	***6.5%***	***7.3%***
4.6%	***7.4%***	***2.9%***	***38.4%***	***Admin Loss Ratio***	***4.6%***	***6.9%***	***2.3%***	***33.9%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Six Months Ending December 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
37,718	54,250	16,532	30.5%	Purchase services	224,773	325,500	100,727	30.9%
172,071	206,000	33,929	16.5%	Depreciation & amortization	1,034,611	1,236,000	201,389	16.3%
19,565	19,750	185	0.9%	Insurance expense	117,389	118,500	1,111	0.9%
115,513	131,583	16,070	12.2%	Repair and maintenance	631,943	789,498	157,555	20.0%
40,482	43,000	2,519	5.9%	Other Operating Expense	332,245	258,000	(74,245)	(28.8%)
(385,348)	(454,583)	(69,235)	(15.2%)	Indirect allocation, Occupancy	(2,340,960)	(2,727,498)	(386,538)	(14.2%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

OTHER INCOME STATEMENTS – DECEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.3) million, unfavorable to budget $0.1 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $1.1 million, favorable to budget $1.0 million

CalOptima
Balance Sheet
December 31, 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$550,438,140	Accounts Payable	$49,206,144
Short-term Investments	955,481,443	Medical Claims liability	793,053,569
Capitation receivable	205,691,498	Accrued Payroll Liabilities	15,138,741
Receivables - Other	64,658,203	Deferred Revenue	9,510,510
Prepaid expenses	12,295,138	Deferred Lease Obligations	124,462
		Capitation and Withholds	174,250,544
Total Current Assets	**1,788,564,422**	**Total Current Liabilities**	**1,041,283,972**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	7,606,244		
505 City Parkway West	51,777,223		
	105,634,552		
Less: accumulated depreciation	(61,038,837)		
Capital assets, net	44,595,715	Other (than pensions) post employment benefits liability	31,886,443
Other Assets		Net Pension Liabilities	30,345,020
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,103,515,435**
Cash and Cash Equivalents	2,231,505		
Investments	584,489,382	**Deferred Inflows**	
Total Board-designated Assets	586,720,887	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	643,819,800	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,476,979,937**	TNE	108,177,918
		Funds in Excess of TNE	1,275,915,739
Deferred Outflows		**TOTAL NET POSITION**	1,384,093,657
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,491,972,234**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,491,972,234**

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CalOptima
Board Designated Reserve and TNE Analysis
as of December 31, 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	240,328,307				
	Tier 1 - MetLife	239,324,316				
Board-designated Reserve		479,652,624	378,748,226	587,430,859	100,904,398	(107,778,235)
	Tier 2 - Payden & Rygel	53,554,523				
	Tier 2 - MetLife	53,513,740				
TNE Requirement		107,068,263	108,177,918	108,177,918	(1,109,655)	(1,109,655)
	Consolidated:	**586,720,887**	**486,926,144**	**695,608,777**	**99,794,743**	**(108,887,890)**
	Current reserve level	*1.69*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
December 31, 2021

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	29,542,252	75,312,864
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	529,306	3,349,375
Changes in assets and liabilities:		
Prepaid expenses and other	(1,096,984)	(316,527)
Catastrophic reserves		
Capitation receivable	344,223,180	204,546,317
Medical claims liability	(23,999,211)	(151,265,378)
Deferred revenue	31,295	(4,076,315)
Payable to health networks	13,137,108	29,470,756
Accounts payable	14,990,051	2,791,724
Accrued payroll	758,691	(1,076,720)
Other accrued liabilities	-	(2,867)
Net cash provided by/(used in) operating activities	378,115,689	158,733,227
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	19,602,299	109,928,363
Change in Property and Equipment	(518,040)	(2,217,215)
Change in Board designated reserves	626,375	2,159,265
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	19,710,633	109,870,414
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	397,826,322	268,603,641
CASH AND CASH EQUIVALENTS, beginning of period	$152,611,818	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**550,438,140**	**550,438,140**

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BALANCE SHEET – DECEMBER MONTH:

ASSETS of $2.5 billion increased $34.5 million from November or 1.4%

- Operating Cash and Short-term Investments net increase of $378.2 million due to the timing of DHCS capitation receipts
  - Operating cash increased $397.8 million
  - Short-term Investments decreased $19.6 million
- Capitation Receivables decreased $348.3 million due to the timing of cash receipts
- Board-Designated Assets decreased $0.6 million

LIABILITIES of $1.1 billion increased $4.9 million from November or 0.4%

- Accounts Payable increased $15.0 million due to the timing of accruals for the quarterly premium tax payment
- Capitation and Withhold increased $13.1 million due to timing of capitation payments
- Claims Liabilities decreased $24.0 million due to timing of claim payments and changes in Incurred But Not Reported (IBNR)

NET ASSETS of $1.4 billion, increased $29.5 million from November or 2.2%

Summary of Homeless Health Initiatives and Allocated Funds
As of December 31, 2021

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

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

This report only lists Board approved projects.

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

Budget Allocation Changes
Reporting Changes for December 2021

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Ground Floor Corridor Heating and Cooling Boxes Replacement	Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	$25,800	To transfer funds from capital project Ground Floor Corridor Heating and Cooling Boxes Replacement to capital project Multiple Bathroom Upgrades (Original Bathrooms on the 2nd and 4th Floors) to fund the final bathroom change order.	2020-21
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Citrix Virtual Servers to Support Version - Hardware	$24,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Citrix Virtual Servers to Support Version to provide additional funds for hardware purchases.	2021-22
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$51,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW - BMC	Maintenance HW/SW – SolarWinds	$10,500	To repurpose funds from BMC to SolarWinds to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Upgrade the Citrix Virtual Servers to Support Version - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$13,500	To transfer funds from capital project Upgrade the Citrix Virtual Servers to Support Version to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW – Optum/Ingenix ICD 10	Maintenance HW/SW – Smart Communications	$14,000	To repurpose funds from Optum/Ingenix ICD10 to Smart Communications to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – Extreme Networks	$24,000	To repurpose funds from Microsoft True-UP to Extreme Networks to provide additional funds for maintenance contract renewal.	2021-22

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

Board of Directors Meeting
February 3, 2022

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare

- 2022 CMS Readiness Checklist (applicable to OneCare and OneCare Connect)

  On October 8, 2021, CMS released the 2022 Readiness Checklist for MAOs (e.g., OneCare) and MMPs (e.g., OneCare Connect). Plans are expected to fulfill key operational requirements summarized in the readiness checklist for the 2022 benefit year. Regulatory Affairs and Compliance (RAC) is leading the 2022 Readiness Checklist validation activities with all applicable departments to ensure compliance for requirements impacting their respective operational area(s). The validation audit has concluded in early January 2022.

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

  CMS conducted a program audit on both OneCare and OneCare Connect. CMS released the preliminary draft audit report on 8/6/21 and completed the exit conference. On October 21, 2021, CMS issued the Draft Audit Report, which noted a total of 11 observations, 8 Corrective Action Required (CARs), and one ICAR. (The ICAR issued on August 27th and the CAP was accepted by CMS on 9/13/21.) As there were no comments/rebuttals to the Draft Audit Report, CMS released the Final Audit Report, with no changes to the findings, on 11/5/21.

  The following table provides a high-level summary of the audit findings by program area:

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2021 CMS Program Audit Final Report Summary			
Overall Final Audit Score – 0.59			
	Immediate Corrective Action Required	**Corrective Action Required**	**Observations**
CPE [1] *[OC; OCC]*	0	0	0
FA [2] *[OC; OCC]*	0	1	1
CDAG [3] *[OC; OCC]*	0	0	1
ODAG [4] *[OC]*	1	0	4
SNP-MOC [5] *[OC]*	0	2	1
SARAG [6] *[OCC]*	0	0	4
CCQIPE [7] *[OCC]*	0	5	0
Total:	**1**	**8**	**11**

[1] CPE = Compliance Program Effectiveness
[2] FA = Formulary Administration
[3] CDAG = Coverage Determinations, Appeals and Grievances
[4] ODAG = Organization Determinations, Appeals & Grievances
[5] SNP-MOC = Special Needs Plan – Model of Care
[6] SARAG = Service Authorization Requests, Appeals, and Grievances
[7] CCQIPE = Care Coordination and Quality Improvement Effectiveness

CalOptima submitted the corrective action plans (CAPs) for the non-ICAR condition on 12/9/21. On 1/5/22, CMS informed CalOptima that the CAPs submitted for the SNP, CCQIPE and FA program areas have been accepted. In terms of next steps, CMS has provided a deadline of 7/5/2022 for CalOptima to complete the independent validation audit (IVA).

CalOptima has chosen a vendor to conduct the IVA and will be working with BluePeak to conduct a mock validation audit ahead of the IVA.

2. OneCare Connect

- CY 2022 Monitoring of Posted Comprehensive Formularies Analysis (PvA)

  On 11/18/21, CMS announced it will be conducting a review to compare the formularies posted on plan websites for CY 2022 to their approved formularies within HPMS that will be effective 1/1/21. CMS will select a random sample of Part D plans for inclusion, excluding PACE organizations, in the CY 2022 Monitoring of Posted Comprehensive Formularies Analysis (PvA).

  On 12/8/21, CMS separately notified CalOptima that its OneCare Connect contract was selected for the CY 2022 PvA.

  On 12/28/21, CalOptima was notified that the review of the comprehensive formulary vs the CMS-approved HPMS formulary has been completed and no potential discrepancies were identified within the review sample. No action is required at this time.

3. PACE

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

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- 2019 One-Third Financial Audit

  On 8/13/20, CMS notified CalOptima PACE that it had been selected for the 2019 CMS Financial Audit. On 10/2/20, CMS' contractor, Meyers & Stauffer, formally engaged CalOptima PACE for this audit. By 12/1/20, CalOptima completed all submissions for the 30-day and the 60-day document requests. On 2/1/21, CalOptima completed all required prescription drug event (PDE) sample submissions. On 4/12 and 4/16, CalOptima participated in a series of conference calls to discuss oversight of delegated entities, policies related to FWA, and reporting of shared expenses as they relate to PACE.

  On 6/18/21, CalOptima attended the exit conference held by Myers & Stauffer. During the call, the draft report was reviewed along with next steps regarding agreeing and/or disagreeing with the findings and observations. On 6/25/21, CalOptima submitted the Agree/Disagree letter to Myers & Stauffer rebutting the finding and agreeing with the observation noted within the draft report.

  On 7/29/21, CMS issued the Final Audit Report for the CY19 PACE One-Third Financial Audit. CMS cited one (1) finding requiring corrective action, and one (1) observation:

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

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

  On 9/16/21, CalOptima submitted its CAP and Attestation to CMS for the finding and observation resulting from the audit.

  On 12/23/21, CMS informed CalOptima that they have made the determination to close the PACE One Third-Financial Audit and that no further action is required. CMS has determined that CalOptima has executed appropriate corrective actions for the finding identified in the audit report.

4. Medi-Cal

- 2021 DHCS Medical Audit:

  On Friday, October 7, 2021, DHCS formally engaged CalOptima for its annual medical audit. The audit will cover CalOptima's provision of Medi-Cal services to its non-Seniors and Persons with Disabilities (non-SPD) and SPD members. This year, due to the COVID-19 health emergency, DHCS intends to conduct its staff interviews via webinar and will not

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

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be onsite. Staff interviews will be conducted from Monday, January 24, 2022, through Friday, February 4, 2022. The Entrance Conference was held on January 24, 2022.

The 2021 DHCS Medical Audit will cover the review period of February 1, 2020 - December 31, 2021 and will assess CalOptima's compliance with its Medi-Cal contract and regulations in the areas of utilization management, case management and coordination of care, member's rights, quality management, access & availability, and administrative and organizational capacity. This year, DHCS will review Kaiser's delegated functions, including Prior Authorization, Appeals, Call Inquiries, Exempt Grievances, and standard Grievances. DHCS will also examine CalOptima's oversight of Kaiser.

At the request of DHCS leadership, the audit will examine an ad-hoc review of post-stabilization authorizations (PSA). For this review, DHCS has selected two (2) health networks (Prospect and FCMG) for review, along with CalOptima. DHCS attempted to review this scope as part of an ad-hoc review in 2020 and was unable to complete it due to the COVID-19 health emergency. CalOptima was informed that PSA would be included in the 2021 DHCS Medical Audit scope.

DHCS is currently reviewing CalOptima supporting documents in preparation for the virtual webinars. As DHCS conducts its reviews and requests additional clarification or information, Medi-Cal RAC works with internal stakeholders to ensure a comprehensive and timely response.

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the months of November and December 2021.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard:

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of July 2021 – November 2021.

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- **Requirement: Routine authorizations Processed ≤ 5 Business Days after receipt of information reasonably necessary to make a decision but no later than ≤ 14 Calendar Days from receipt of request.**

Goal	Sept.	Oct.	Nov.
98%	49.58%	51.19 %	58.92%

  - Medi-Cal Utilization Management metrics for Timely Routine Authorizations identified three (3) consecutive months of falling below compliance goal.
  - CalOptima's Audit & Oversight (A&O) department will issue a request for a corrective action plan (CAP) for deficiencies identified. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

- **Requirement: Expedited Authorizations Resolved ≤ 72 Hours After Receipt; may be Extended up to 14 Calendar Days**

Goal	Sept.	Oct.	Nov.
98%	90.36%	84.74%	92.38%

  - Medi-Cal Utilization Management metrics for Timely Expedited Authorizations identified three (3) consecutive months of falling below compliance goal.
  - CalOptima's Audit & Oversight (A&O) department will issue a request for a corrective action plan (CAP) for deficiencies identified. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

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

- Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Timely Effectuation	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
August 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A
September 2021	100%	94%	100%	100%	26%	N/A	100%
October 2021	100%	94%	100%	100%	82%	88%	100%

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- Based on a focused review of nineteen (19) Medi-Cal standard appeals for September 2021, the lower compliance score of 94% for standard appeals acknowledgement was due to one (1) untimely issuance of an acknowledgement letter.
- Based on a focused review of nineteen (19) Medi-Cal standard appeals for September 2021, the lower compliance score of 26% for member notice content was due to fourteen (14) resolution letters were not written in 6th grade reading level.
- Based on a focused review of seventeen (17) Medi-Cal standard appeals for October 2021, the lower compliance score of 94% for standard appeals acknowledgement was due to one (1) untimely issuance of an acknowledgement letter.
- Based on a focused review of seventeen (17) Medi-Cal standard appeals for October 2021, the lower compliance score of 82% for member notice content was due to three (3) untimely effectuations.
- Based on a focused review of seventeen (17) Medi-Cal standard appeals for October 2021, the lower compliance score of 88% for timely effectuation was due to two (2) untimely effectuations.

- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Clinical Decision Making	Timely Effectuation	Member Notice Content	Resolution of Expedited Appeals within 72 Hours of Receipt
August 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A
September 2021	100%	N/A	100%	100%	N/A	0%	100%
October 2021	100%	N/A	100%	100%	66%	100%	100%

- Based on a focused review of one (1) Medi-Cal expedited appeals for September 2021, the lower compliance score of 0% for member notice content was due to one (1) untimely issuance of an acknowledgement letter.
- Based on a focused review of three (3) Medi-Cal expedited appeals for October 2021, the lower compliance score of 66% for timely effectuation was due to one (1) untimely effectuation.

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances within ≤ 30 Calendar Days of Receipt
August 2021	100%	100%	100%	85%	100%
September 2021	100%	100%	100%	94%	100%

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

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October 2021	100%	100%	100%	76%	100%

- Based on a focused review of seventeen (17) Medi-Cal standard grievances for September 2021, the lower compliance score of 94% for member notice content was due to one (1) resolution letter had the incorrect date when the grievance was received.
- Based on a focused review of sixteen (16) Medi-Cal standard grievances for October 2021, the lower compliance score of 76% for member notice content was due to an incomplete resolution, a member issue was not addressed, a medical director's recommendation was not included in the resolution letter, and a resolution specialist did not address the root cause of the delay in the authorization getting approved.

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
August 2021	100%	100%	100%	0%	100%
September 2021	100%	100%	100%	50%	100%
October 2021	100%	100%	100%	67%	100%

- Based on a focused review of four (4) Medi-Cal expedited grievances for September 2021, the lower compliance score of 50% for member notice content was due to a member's issue was not resolved and a resolution letter did not include the telephone number of the Plan representative who may be contacted about the grievance.
- Based on a focused review of three (3) Medi-Cal expedited grievances for October 2021, the lower compliance score of 67% for member notice content was due to a delay in providing prior authorizations for services.

- Medi-Cal Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2021	100%	90%	100%	100%	N/A	100%	60%
September 2021	100%	0%	100%	100%	N/A	100%	100%
October 2021	100%	10%	100%	100%	N/A	100%	83%

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- Based on a focused review of ten (10) Medi-Cal standard prior authorizations for September 2021, the lower compliance score of 0% for resolution timeliness was due to untimely resolution of ten (10) standard prior authorizations.
- Based on a focused review of ten (10) Medi-Cal standard prior authorizations for October 2021, the lower compliance score of 10% for resolution timeliness was due to nine (9) untimely resolutions.
- Based on a focused review of six (6) Medi-Cal standard prior authorizations for October 2021, the lower compliance score of 83% for accuracy of member notice content was due to one (1) description of service was not in lay language.

- Medi-Cal Utilization Management: Urgent Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2021	100%	100%	100%	100%	N/A	100%	100%
September 2021	100%	80%	100%	100%	N/A	100%	50%
October 2021	100%	60%	100%	100%	N/A	100%	100%

- Based on a focused review of five (5) Medi-Cal urgent prior authorizations for September 2021, the lower compliance score of 80% for resolution timeliness was due to untimely resolution of one (1) urgent prior authorization.
- Based on a focused review of two (2) Medi-Cal urgent prior authorizations for September 2021, the lower compliance score of 50% for accuracy of member notice content was due to a staff involved did not follow UM's established processes regarding processing of one (1) NOA letter.
- Based on a focused review of five (5) Medi-Cal urgent prior authorizations for October 2021, the lower compliance score of 60% for resolution timeliness was due to two (2) untimely resolution of urgent prior authorizations.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
August 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

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September 2021	100%	100%	100%	100%	100%	100%
October 2021	100%	100%	100%	50%	100%	100%

- No significant trends to report in September 2021.
- Based on a focused review of two (2) OneCare standard appeals for October 2021, the lower compliance score of 50% for clinical decision making was due one (1) incomplete effectuation of authorized service.

- OneCare GARS: Payment Reconsiderations (PREC)

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

- No significant trends to report in September 2021.
- Nothing to report for October 2021.

- OneCare GARS: Standard Grievances

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
August 2021	100%	100%	100%	100%	100%
September 2021	100%	100%	100%	83%	100%
October 2021	100%	100%	100%	92%	100%

- Based on a focused review of eighteen (18) OneCare standard grievances for September 2021, the lower compliance score of 83% for member notice content was due to one (1) resolution letter had the incorrect date when the grievance was received.
- Based on a focused review of twelve (12) OneCare standard grievances for October 2021, the lower compliance score of 92% for member notice content was due to not all issues

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were addressed, and a letter did not meet 6th grade readability/no documentation to support provider statements in resolution letter.

- OneCare Utilization Management: Standard Pre-Service Organization Determinations (SOD)

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2021	100%	75%	100%	100%	N/A	100%	100%
September 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A
October 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A

  - Nothing to report for October 2021.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
August 2021	100%	100%	100%	100%	100%	100%
September 2021	100%	87.50%	100%	100%	100%	100%
October 2021	100%	100%	100%	100%	100%	100%

  - Based on a focused review of eight (8) OneCare Connect standard appeals for September 2021, the lower compliance score of 87.50% for standard appeals acknowledgement was due to one (1) untimely issuance of an acknowledgement letter.
  - No significant trends to report in October 2021.

- OneCare Connect GARS: Expedited Appeals

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

- Nothing to report for September 2021.
- No significant trends to report in October 2021.

- OneCare Connect GARS: Standard Grievances

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

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for September 2021, the lower compliance score of 93% for member notice content was due to one (1) resolution letter did not address why the doctor changed medication to milligrams.
- No significant trends to report in October 2021.

- OneCare Connect GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledge within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
August 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
September 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

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October 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

➢ Nothing to report in September and October 2021.

- OneCare Connect Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2021	100%	90%	100%	100%	N/A	100%	100%
September 2021	100%	100%	100%	100%	N/A	100%	90%
October 2021	100%	100%	100%	100%	100%	100%	90%

➢ Based on a focused review of ten (10) OneCare Connect standard prior authorizations for September 2021, the lower compliance score of 90% for accuracy of member notice was due to one (1) inaccurate member notice.
➢ Based on a focused review of ten (10) OneCare Connect standard prior authorizations for October 2021, the lower compliance score of 90% for accuracy of member notice was due to one (1) description of service was not in lay language.

- OneCare Connect Utilization Management: Expedited Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
August 2021	100%	100%	100%	100%	N/A	100%	90%
September 2021	100%	100%	100%	100%	100%	N/A	100%
October 2021	100%	100%	100%	100%	100%	N/A	100%

➢ No trends for September or October 2021.

5. Internal Auditing: [a\]

- 2021 Internal Audit: GARS, Customer Service and Quality Improvement (Medi-Cal)

➢ During the fourth quarter of 2021, CalOptima's Audit & Oversight (A&O) department conducted a Medi-Cal audit of CalOptima's Grievances & Appeals, Customer Service,

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and Quality Improvement departments to ensure compliance with universe integrity, timeliness, clinical decision-making, and processing validation for medical grievances, medical appeals, customer service and potential quality of care issues for the review period January 1, 2021 through August 31, 2021.

Area Assessed	Universe Validation	Universe Integrity	Classification Score	Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievances: Standard: Resolved 30 Calendar Days of Receipt Expedited: Resolved ≤ 72 hours of Receipt
Medical Grievances	100%	90%	100%	93.33%	100%	70%	80%

- The lower compliance score of 90% for Universe Integrity was due to inaccurate data in the universe.
- The lower compliance score of 93.33% for Grievance Acknowledged ≤ 5 Calendar Days of Receipt was due to one (1) out of fifteen (15) files had untimely grievance acknowledgments.
- The lower compliance score of 70% for Member Notice Content was due to six (6) out of twenty (20) files had inaccurate member notice content.
- The lower compliance score of 80% for Resolution of Grievances was due to four (4) out of twenty (20) files had untimely grievance resolutions.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's GARS department universe, timeliness, and accuracy. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

Area Assessed	Universe Validation	Classification Score	Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Appeals Involving Denied Medical Necessity	Member Notice Content	Resolution of Appeals: Standard: Resolved 30 Calendar Days of Receipt Expedited: Resolved ≤ 72 hours of Receipt
Medical Appeals	100%	100%	70%	100%	90%	35%	95%

- The lower compliance score of 70% for Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt was due to one (1) out of fifteen (15) files had untimely appeals acknowledgment.
- The lower compliance score of 90% for Appeals Involving Denied Medical Necessity was due to two (2) out of twenty (20) files did not have clear and concise explanations of the Plan's decision.
- The lower compliance score of 35% for Member Notice Content was due to thirteen (13) out of twenty (20) files had inaccurate member notice content.
- The lower compliance score of 95% for Resolution of Appeals was due to one (1) out of twenty (20) files had untimely appeals resolutions.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's GARS

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department universe, timeliness, and accuracy. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

Area Assessed	Universe Validation	Classification Score	File Review
Customer Service Inquiries	100%	94.44%	95.80%

- The lower compliance score of 94.44% for Classification Score was due to two (2) out of eighteen (18) files was misclassified.
- The lower compliance score of 95.80% for File Review was due to two (2) out of seventeen (17) files had failed to adhere to the privacy rule.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's Customer Service department universe, timeliness, and accuracy. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

Area Assessed	Universe Validation	Universe Accuracy	Classification of Exempt	Accurate Documentation of Exempt Grievance	Complete Resolution of Exempt Grievance	Resolution Turn-Around Time (1 Business Day)
Customer Service Exempt Grievances	100%	73.91%	100%	100%	100%	75%

- The lower compliance score of 73.91% for Universe Accuracy was due to six (6) out of twenty-three (23) files had inaccurate data in the universe.
- The lower compliance score of 75% for Resolution Turn-Around Time was due to five (5) out of twenty-four (24) files had untimely resolutions.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's Customer Service department universe, timeliness, and accuracy. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

Area Assessed	Universe Validation	Universe Integrity	Timeliness	Member Notification	Provider Notification	Clinical Decision Making
Potential Quality of Care Issue	100%	50%	17%	100%	100%	67%

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- The lower compliance score of 50% for Universe Integrity was due to three (3) out of six (6) files had inaccurate data in the universe.
- The lower compliance score of 17% for Timeliness was due to five (5) out of twenty-six (6) files had untimely processing.
- The lower compliance score of 67% for Clinical Decision Making was due to two (2) out of six (6) files had wrong member records, failed to request medical records timely, and untimely initial clinical review.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's Quality Improvement department universe, timeliness, and accuracy. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

- 2021 Internal Audit: Quality Analytics - Access and Availability (Medi-Cal)

  - During the fourth quarter of 2021, CalOptima's Audit & Oversight (A&O) department conducted a Medi-Cal audit of CalOptima's Quality Analytics department to ensure compliance with policies and procedures related to access and availability standards, reporting and trending analysis, monitoring activities and quarterly reporting for the review period February 1, 2021, through August 31, 2021.

Area Assessed	Access and Accessibility
Quality Analytics	92.07%

  - The lower compliance score of 92.07% for Access and Accessibility was due to the following deficiencies: appointment availability did not meet minimum compliance standard, practitioner telephone wait time during business hours, and availability of PCP practitioners.
  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's Quality Analytics department access and availability standards, reporting and trending analysis, monitoring activities and quarterly reporting. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

- 2021 Internal Audit: Programs of All-Inclusive Care for the Elderly (PACE)

  - During the fourth quarter of 2021, CalOptima's Audit & Oversight (A&O) department conducted a Programs of All-Inclusive Care for the Elderly (PACE) audit of CalOptima's PACE department to ensure compliance with universe integrity, timeliness, and clinical decision-making for grievances, appeals, after hour calls, list of personnel, participant medical records and service delivery requests for the review period January 1, 2021 through August 31, 2021.

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

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Area Assessed	Universe Validation	SDR Denials	SDR Approvals
Service Delivery Requests (SDR)	100%	0%	77.78%

- The lower compliance score of 0% for SDR Denials was due to one (1) out of one (1) file did not have the appropriate templates.
- The lower compliance score of 77.78% for SDR Approvals was due to two (2) out of nine (9) files had inaccurate data in the universe.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's PACE department access and availability standards, reporting and trending analysis, monitoring activities and quarterly reporting. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

Area Assessed	
Appeal Requests (AP)	Nothing to Report

- Nothing to report.

Area Assessed	Universe Validation	Data Integrity	Classification Score	Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Participant Notice Content	Resolution of Grievances resolved ≤ 30 Calendar Days of Receipt
Grievance Requests (GR)	100%	0%	100%	100%	90%	0%	100%

- The lower compliance score of 0% for Data Integrity was due to inaccurate data in the universe.
- The lower compliance score of 90% for Language Preference was due to one (1) out of ten (10) files did not have the acknowledgement letter, resolution letter, and related inserts in the participant's threshold language.
- The lower compliance score of 0% for Participant Notice Content was due to ten (10) out of ten (10) files did not have the appropriate templates.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's PACE department access and availability standards, reporting and trending analysis, monitoring activities and quarterly reporting. The A&O department continues to work

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with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

Area Assessed	Universe Validation	Data Integrity	Licensure	OIG Exclusions	Background Checks	Clearance of Communicable diseases and immunizations records up-to-date	Personnel Training / Qualifications for Direct Care
List of Personnel (LOP)	0%	70%	100%	88.89%	100%	100%	55.56%

- The lower compliance score of 0% for Universe Validation was due 3 (three) failed attempts to produce a clean universe.
- The lower compliance score of 70% for Data Integrity was due to inaccurate data in the universe.
- The lower compliance score of 88.89% for OIG Exclusions was due to one (1) out of nine (9) files did not have record of the original OIG exclusion check.
- The lower compliance score of 55.56% for Personnel Training/Qualifications for Direct Care was due to four (4) out of nine (9) files showed delays in staff receiving, upon hire and competency evaluations.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's PACE department access and availability standards, reporting and trending analysis, monitoring activities and quarterly reporting. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

Area Assessed	Universe Validation	Adequate Care	IDT Participation	Assessments	Medical Record Accuracy	Care Plan Development
List of Participant Medical Records (LOPMR)	100%	100%	100%	100%	100%	100%

- No significant trends to report.

Area Assessed	Universe Validation
On-call Universe (OCU)	100%

- No significant trends to report.

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

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

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
August 2021	90%	91%	96%	89%	88%	89%	98%	93%	87%	99%	60%	100%	100%
September 2021	90%	91%	96%	84%	93%	92%	97%	94%	83%	100%	82%	92%	96%
October 2021	91%	89%	97%	88%	94%	90%	96%	85%	85%	98%	100%	93%	99%

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for timeliness during the month October 2021. Of the thirty (30) files submitted in the aggregate by three (3) health networks, eight (8) files were deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for decision (Urgent 72 hours, Routine – 5 business days, and Extended– 14 calendar days)
  - Failure to meet timeframe for provider initial notification (24 hours & 5 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for member notification (2 business days & 5 business days)
- Based on a focused review of select files, seven (7) health networks drove the lower compliance score for clinical decision making (CDM) during the month of October 2021. Of the fifty-one (51) files submitted in the aggregate by seven (7) health networks, thirty-nine (39) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
  - Failure to cite criteria for decision
  - Failure to obtain adequate clinical information
  - Failure to include appropriate professional that makes decision
- Based on a focused review of select files, six (6) health networks drove the lower compliance score for letter criteria during the month of October 2021. Of fifty-three (53) files submitted in the aggregate by six (6) health networks, seventeen (17) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to provide information on how to file appeal and grievance
  - Failure to provide letter in member preferred language
  - Failure to provide why the request did not meet the criteria in lay language
  - Failure to provide description of service in lay language

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

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- Failure to provide name and contact information for health care professional responsible for the decision to deny or modify
- Failure to provide Language Assistance Taglines insert with approved threshold languages
- Failure to provide referral back to primary care provider (PCP) on denial letter
- Failure to provide peer-to-peer discussion of the decision with medical reviewer

➢ Based on the overall universe of Medi-Cal authorizations for October 2021, CalOptima's health networks received an aggregate compliance score of 99.80% for timely processing of routine authorization requests and a compliance score of 99.41% for timely processing of expedited authorization requests.

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

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2021	80%	89%	89%	95%
September 2021	88%	96%	93%	98%
October 2021	87%	95%	94%	95%

➢ Based on a focused review of selected files seven (7) health networks drove the lower compliance score for Paid Claims Timeliness during the month of October 2021. Of the seventy- eight (78) files submitted in the aggregated by the seven (7) health networks, sixteen (16) files were deficient due to failure to the following:

- Failure to meet paid claims timeliness
- Failure to meet paid claims accuracy

➢ Based on a focus review of select files, five (5) health networks drove the lower compliance score for Paid Claims Accuracy during the month of October 2021. Of the sixty-three (63) files submitted in the aggregate by five (5) health networks, eight (8) files were deficient due to the following:

- Failure to process - missing documentation for clean claims processing

➢ Based on a focus review of select files, five (5) health networks drove the lower compliance score for Denied Claims Accuracy during the month of October 2021. Of the one hundred forty-six (146) files submitted in the aggregate by five (5) health networks, nineteen (19) files were deficient due to the following:

– Failure to provide all necessary documentation for clean claims processing

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

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- Failure to provide a valid claims denial reason, or denying in error (e.g., invalid CPT code or ICD code)

- Based on the overall universe of Medi-Cal claims for October 2021, CalOptima's health networks received an overall compliance score of 82% for timely processing of claims.
- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

7. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
August 2021	100%	100%	96%	100%	95%	98%	92%	100%
September 2021	100%	92%	97%	99%	91%	88%	93%	100%
October 2021	92%	100%	96%	99%	97%	100%	100%	100%

- Based on a focused review of selected files, two (2) health networks drove the lower compliance score for timeliness during the month of October 2021. Of the seven (7) files submitted by the two (2) health networks, two (2) files were deficient for timeliness.
  - Failure to meet timeframe for member notification (Routine – 14 calendar days)
  - Failure to meet timeframe for provider notification (Routine – 14 calendar days)
- Based on a focused review of select files, two (2) health networks drove the lower compliance score for letter criteria during the month of October 2021. Of the seven (7) files submitted by the two (2) health networks three (3) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to provide description of service in lay language
- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for October 2021, CalOptima's health networks received an overall compliance score 98% for timely processing of standard Part C authorization requests and 82% for timely processing of expedited Part C authorization requests.

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

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

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2021	98%	99%	99%	96%
September 2021	86%	91%	95%	45%
October 2021	95%	96%	99%	83%

- Overall scores for OneCare Claims increased in the aggregate for the October 2021 file review month.
- Based on the overall universe of OneCare claims for October 2021, CalOptima's health networks received an overall compliance score of 78% for timely processing of claims.
- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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

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

Month	Timeliness for Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timeliness for Routine Requests	Letter Score for Routine Requests	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests
August 2021	96%	93%	93%	97%	92%	69%	85%	99%	83%	92%	99%
September 2021	99%	87%	89%	93%	92%	83%	92%	97%	68%	84%	97%

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

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October 2021	92%	100%	92%	93%	97%	97%	85%	99%	72%	83%	100%

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for timeliness during the month of October 2021. Of the twenty-four (24) files submitted in the aggregate by the three (3) health networks, four (4) files were deficient for timeliness. The deficiency for the lower score for timeliness were due to the following:
  - Failure to meet timeframe for provider written notification (Urgent – 72 hours & Routine 5 – business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
- Based on a focused review of select files, four (4) health network drove the lower compliance score for clinical decision making (CDM) during the month of October 2021. Of the twenty-one (21) files submitted in the aggregate by the four (4) health networks, sixteen (16) files were deficient for CDM. The lower scores for CDM were due to the following:
  - Failure to cite criteria for decision
- Based on a focused review of select files, one (1) health network drove the lower compliance score for letter criteria during the month of October 2021. Of two (2) files submitted in the aggregated by the one (1) health network, one (1) file was deficient for letter criteria. The deficiency for the lower score for letter criteria were due to the following:
  - Failure to provide peer to peer discussion of the decision with medical reviewer
  - Failure to provide health care professional telephone number responsible for decision (to provider)
- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for October 2021, CalOptima's health networks received an overall compliance score of 99.80% for timely processing of routine authorization requests and 100% for timely processing of expedited authorization requests.
- CalOptima's utilization management department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of prior authorization requests. The utilization management department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

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- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2021	91%	87%	99%	93%
September 2021	84%	92%	98%	76%
October 2021	79%	86%	94%	88%

- Based on a focused review of select files, four (4) health networks drove the lower compliance score for Approved Paid Claims Timeliness during the month of October 2021. Of the four (4) health networks that submitted forty (40) files in the aggregate, sixteen (16) files were deficient for timeliness. The deficiency for the lower score for timeliness was due to the failure to meet non-contracted clean denied claim timeliness (30 calendar day from date of claim receipt).
- Based on a focused review of selected files, two (2) health networks drove the lower compliance scores for Denied Claims Timeliness during the month of October 2021. Of the two (2) health network that submitted thirty-two (32) files in the aggregate, four (4) files were deficient due to the following:
  - Failure to meet non-contracted clean paid claim timeliness (30 calendar day from date of claim receipt)
  - Failure to provide documentation required for claims processing
- Based on a focused review of selected files, five (5) health networks drove the lower compliance scores for Denied Claims accuracy during the month of October 2021. Of the five (5) health networks that submitted fifty-eight (58) files in the aggregate, twenty-two (22) files were deficient due to the following:
  - Failure to provide documentation required for claims processing
- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for October 2021, CalOptima's health networks received the following overall compliance scores:
  - 97%for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 91%for non-contracted and contracted unclean claims paid or denied within 60 calendar days of receipt
  - 100% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt
- CalOptima's claims management department issued requests for corrective action plans (CAPs) or Pre – CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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

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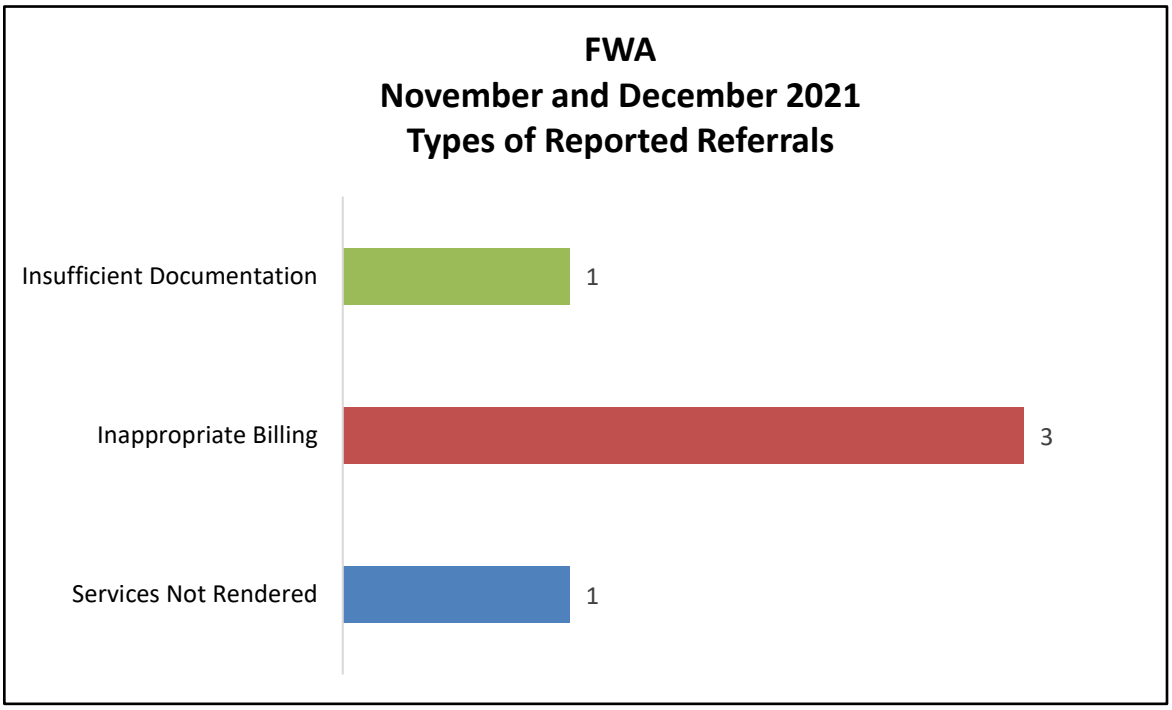
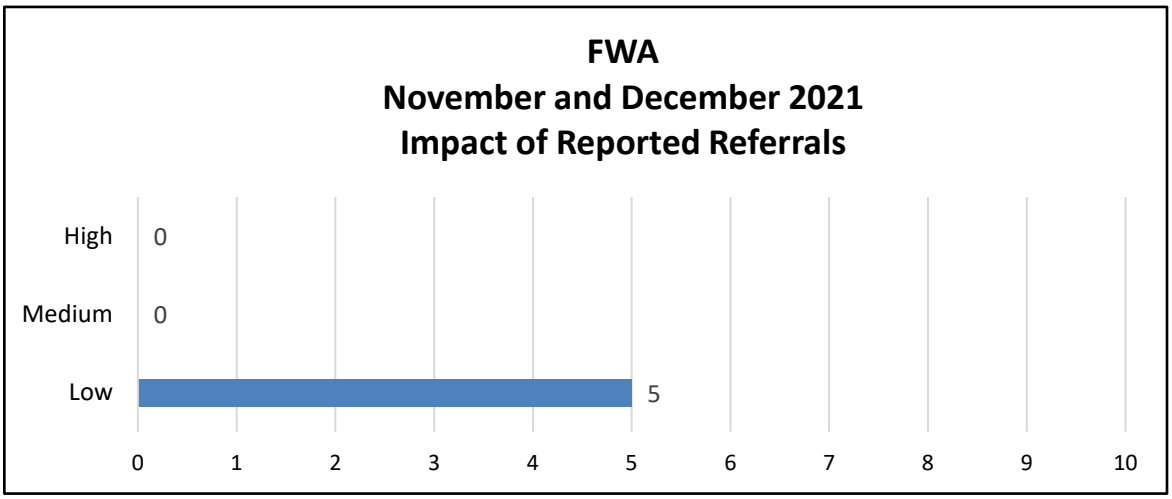
D. Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Referred in November and December 2021)





Total Number of New Cases Referred to DHCS (State)	4
Total Number of Closed Cases Referred to I-MEDIC (CMS)	1
Total Number of Referrals Reported	**5**

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

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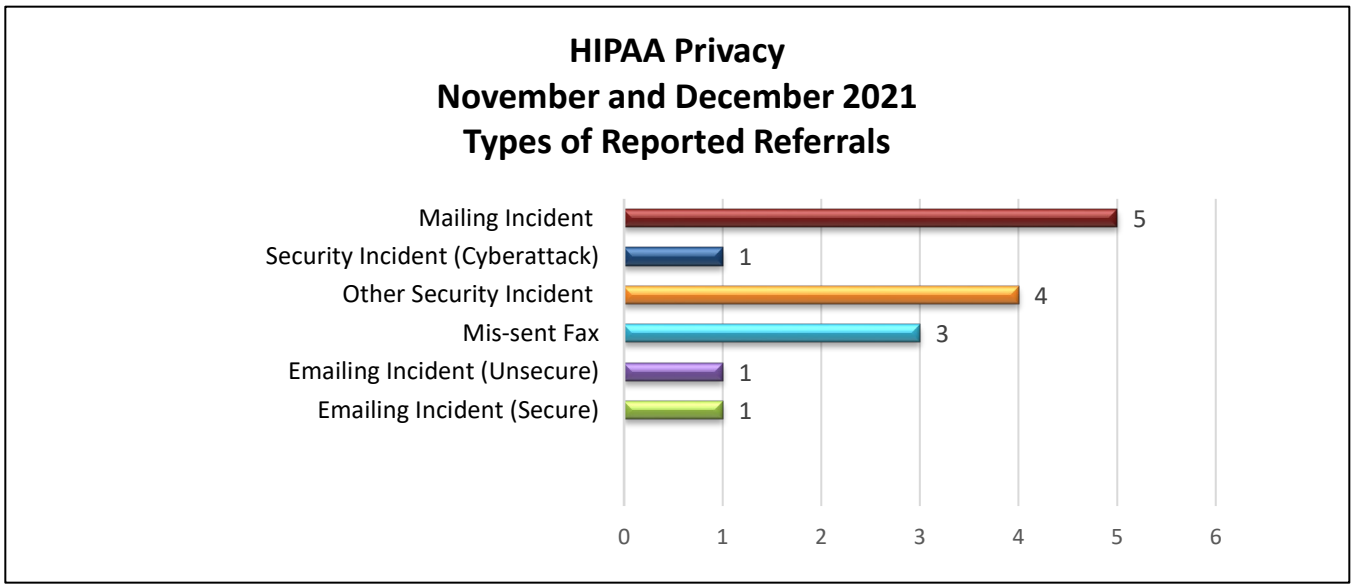
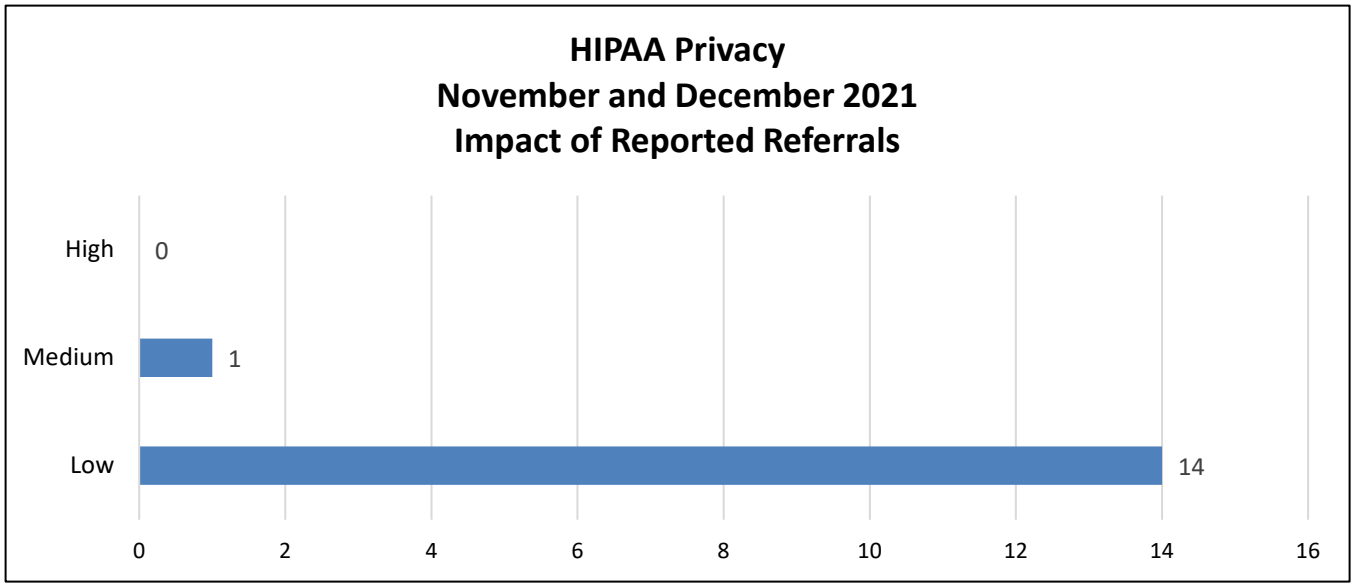
E. Privacy Update: (November and December 2021)





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

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

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E. Privacy Update: (cont.)

1. Regulatory Audit / Investigation

- Health & Human Services (HHS) Office for Civil Rights (OCR) Data Request

  On October 12, 2021, CalOptima submitted a breach notification report to the OCR for a mailing incident involving COVID-19 vaccine incentive gift card approval letters, which was improperly sent to the wrong addresses and inadvertently disclosing 4,732 CalOptima Members' protected health information.

  On November 17, 2021, the OCR sent CalOptima a Data Request letter to investigate whether CalOptima is in compliance with the applicable Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information, and the Breach Notification Rule.

  On December 23, 2021, CalOptima provided the OCR its responses to the requested information. The OCR is currently reviewing the submitted documents.

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

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POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

MEMORANDUM

January 14, 2022

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: January Board of Directors Report

BUDGET RECONCILIATION (BUILD BACK BETTER ACT)

Shortly before recessing for the Holidays, Senator Joe Manchin (D-WV) announced that he would oppose the Build Back Better Act (budget reconciliation bill) in its current form. Without Sen. Manchin's support, Senate Democrats do not have the 50 votes necessary to pass the budget reconciliation bill as currently drafted. Senate Democrats have been working on a revised version of the bill in an effort to secure support from Senator Manchin. Negotiations in the Senate are ongoing, and we are closely monitoring any developments on new funding provisions, or changes to legislative text. Additionally, we are also closely monitoring the Provider Relief Fund. HHS is expected to release about $8 billion from the Provider Relief Fund this month — the second payout from the Phase 4 payment tranche. More than $20 billion remains in the PRF. As hospitals and other providers struggle with the impact of COVID-19 and the increase of cases due to the omicron variant, Congress may consider additional aid.

FISCAL YEAR 2022 APPROPRIATIONS

The current **Continuing Resolution** funding the government (H.R. 6119) will expire on February 18, 2022. Congress has until then to pass the FY22 appropriations bills, or another CR will be necessary to avoid a government shutdown. As previously reported, the House was able to pass all but three of their FY22 spending bills: 1) Commerce-Justice-Science, 2) Defense, and 3) Homeland Security. The Senate Appropriations Committee marked up and advanced their FY22 Agriculture, Energy & Water, and Military Construction-Veterans' Affairs spending bills in August. House and Senate Appropriations leadership, however, remains at an impasse on the topline spending levels for defense and nondefense discretionary spending. The President's FY23 budget is expected to be released in February, but late negotiations on FY22 spending accounts may cause delays. The President's non-binding budget outlines the Administration's priorities for the year and is used to kickstart the annual appropriations process.

VACCINE MANDATE

This month the Supreme Court met for a special session to hear oral arguments on whether the White House has the legal authority to issue vaccine mandates for private businesses. On January

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13, the Supreme Court ruled 6-3 to stay the vaccine mandate for private businesses of 100 or more employees pending a final review. In the majority opinion (found here), the OSHA vaccine mandate exceeded the authority of OSHA's authorizing law, primarily because a vaccination "cannot be undone at the end of the workday" and because the mandate itself acts as a blunt instrument that does not take into account risk factors at different workplaces, citing the Secretary of Labor's estimation that only 9% of landscapers and groundskeepers qualify as working outside exclusively.

In contrast, the Court upheld the vaccine mandate (5-4) for healthcare workers at facilities that administer federal health programs. In this decision, the Court noted that "One such function [of Medicare and Medicaid administration]—perhaps the most basic, given [HHS'] core mission—is to ensure that the healthcare providers who care for Medicare and Medicaid patients protect their patients' health and safety." In short, the vaccine mandate for healthcare workers was ruled to be in-line with existing law which requires providers to enforce an infection prevention and control program. The ruling can be found here.

These expedited decisions came after CMS recently released guidance and details on survey procedures for assessing and maintaining compliance with the November 5 interim final rule healthcare provider vaccination mandate in those states where it may be enforced, or about 25 states and the District of Columbia. The guidance document found here, and the CMS FAQ, here.

Further complicating the vaccine mandates and distribution, according to a draft report, HHS is unprepared to assume full responsibility for the nation's Covid vaccine program, including activities currently managed by the Pentagon. In May 2021, the Biden Administration ordered HHS to begin assuming responsibilities of the program shared with DOD by the end of 2021. However, the report by the U.S. Government Accountability Office suggests that HHS does not have the staff to undertake the responsibilities of the program. HHS claims that it has transitioned the program "successfully" by the beginning of this year but with the surge underway, this report will ask even more questions of how it is currently being handled. Click here for the details.

SURPRISE BILLING

CMS rules on the "**No Surprises Act**" went into effect January 1, 2022, despite pushback from the provider community. Just in time for the implementation, CMS released frequently asked questions on one of the most controversial elements of the new law – Good Faith Estimates. The six-page document discusses which providers are required to provide the estimates, what to do when more than one provider is involved in the procedure, how to handle insured vs. uninsured, and forms to provide patients. Click here for the implementation FAQ, and here for the patient FAQ. An in-depth memo prepared by Strategic Health Care can be found here.

TELEHEALTH FUNDING

Medicare waivers due to the public health emergency led to an increase in telehealth visits from 840,000 in 2019 to 52.7 million in 2020, a 63-fold increase, according to a new report released by HHS' Office of the Assistant Secretary for Planning and Evaluation. Not surprisingly, behavioral health providers saw the highest telehealth utilization relative to other providers. States with the

highest use of telehealth in 2020 included Massachusetts, Vermont, Rhode Island, New Hampshire and Connecticut, and the lowest use of telehealth in 2020 included Tennessee, Nebraska, Kansas, North Dakota and Wyoming. Click here for the press release, and here for the report.

MEDICARE ADVANTAGE PRIOR AUTHORIZATION RULES: CMS REQUESTS MORE INFORMATION

Early in the pandemic, CMS released a memo that detailed requirements for Medicare Advantage Organizations and Part D Sponsors under 42 CFR § 422.100. Among the requirements that Governors may implement, if an emergency is declared, is to waive requirements for referrals. CMS encouraged MA organizations to waive prior authorizations under the memo; this happened to varying degrees depending on states and MA plans. Under the recent MA proposed rule, CMS is soliciting information on the impact of MA organizations' prior authorization requirements for patient transfer on a hospital's ability to effectively manage resources and provide appropriate and timely care during a Public Health Emergency. Comments are due at the beginning of March. Click here for the CMS memo, here for 42 CFR § 422.100, and here for the proposed rule with the RFI. A January 6 press release can also be found here.

NEW TREASURY RULES GIVE MORE FLEXIBILITY TO STATE AND LOCAL PANDEMIC FUNDS

The U.S. Department of the Treasury issued a final rule regarding the use of the $350 billion appropriated for state, local, and tribal governments through the State and Local Fiscal Recovery Funds (SLFRF) program. Treasury distributed $245 billion in 2021, with the remainder to be distributed after March 11, 2022. The final rule gives more flexibility in how the money can be spent. It expands support for public-sector hiring and makes it easier for localities to provide premium pay for essential workers and allows certain capital expenditures to support public health. The rule is effective April 1, 2022, although recipients may take advantage of the flexibilities now. Click here for the Final Rule (Executive Summary, page 6). Details regarding capital expenditures are included on pages 60 and 190. Click here for Treasury's Overview and here for the press release.

EDELSTEIN GILBERT ROBSON & SMITH LLC

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

January 14, 2022

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

This week there has been a lot of media coverage about universal health care policies put forth by both the legislature and the Governor. Despite some initial confusion, the two plans are very different.

On Thursday, January 6, 2022, Assembly Member Kalra introduced Assembly Constitutional Amendment (ACA) 11, which is the financing component to his AB 1400, his measure proposing a single payer state health care program. This package effort ties the legislative life of both bills to each other, which means the financing provisions of ACA 11 cannot go into effect until AB 1400 becomes operative in state law.

AB 1400 – the policy bill

AB 1400, the legislation outlining the structure for a single payer health care system, will likely pass several committees. AB 1400 requires a simple majority vote in order to move forward in the Assembly and State Senate. With Democrats firmly in control of both houses (more than a two-thirds supermajority in the Assembly and Senate), it is anticipated that AB 1400 will be able to garner enough "ayes" to force a floor vote in the Assembly. The bill already passed out of the Assembly Health Committee with all Democrats voting in favor of the bill. However, several Democrats voiced concerns with the bill. The Appropriations Committee will now consider the fiscal impacts of the bill, which may be difficult considering the fiscal elements of the policy are contained in ACA 11.

ACA 11 – the financing component

Assembly Constitutional Amendment (ACA) 11, as currently written, generates some of the necessary revenue to fund a single payer health care system by mandating a set of unprecedented new business and personal income tax increases. The business tax increases will affect most business in California (a new 2.3% excise tax on any business with income greater than $2 million AND a new 1.25% payroll tax on all employers in the state with greater than 49 employees). There is also an additional 1% payroll tax on employees earning more than $49,000. In addition to impacting the entire business community, ACA 11 would also increase the personal income tax on a sliding scale on every individual in the state who earns more than $149,500 a year.

The reason for these unprecedented tax increases is that the Legislative Analyst's Office (LAO) has estimated the cost of a single payer health care system in California will require $200–$400 billion in new revenue. Voting for a massive tax increase,

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especially in an election year, is politically difficult for most legislators. Furthermore, ACA 11 requires a 2/3 vote of the Legislature, making it very unlikely to pass.

Governor Proposes Universal Health Care

Meanwhile, the Governor's proposed budget puts forth a "universal health care" policy whereby full-scope Medi-Cal is extended to all low-income individuals regardless of immigration status. This policy would add 764,000 enrollees to Medi-Cal. The Governor continues to describe this proposal as universal health care, which has led many to believe he is supporting a one-payer health care system. This has led the media to take him to task on several occasions. He has defended the proposal by claiming California will be the first state to make health care available to every Californian. The key difference between the two proposals is who would be covered — the Governor is proposing the State provide coverage for all income-eligible Californians while AB 1400 would cover all Californians under a single-payer system. We predict the Governor's plan will pass and become law, while the single payer health proposal fails.

Medi-Cal Community Based Mobile Crisis Services

Another proposal in the Governor's proposed budget adds a Medi-Cal benefit. The American Rescue Plan Act of 2021 authorizes 85-percent federal matching funds for a Medicaid mobile crisis response services benefit. Therefore, the Department of Health Care Services (DHCS) will add multi-disciplinary mobile response services for crises related to mental health and substance use disorders as a new Medi-Cal benefit, as soon as January 1, 2023. The goal is to help reduce the impact of untreated behavioral health conditions on emergency departments and psychiatric facilities, by providing a system for triaging and referring people to services in the community.

AB 1355 – Independent Medical Review

A bill we are watching closely is AB 1355, which would establish an Independent Medical Review (IMR) process at the DHCS. The bill applies to medical coverage appeals from enrollees receiving care from health plans not regulated by the Department of Managed Health Care. Most County Organized Health System (COHS) would be impacted by the bill. DHCS would be responsible for implementing and paying for the IMR, so there does not appear to be any significant impact to CalOptima, so long as the bill is not amended with new language.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4735 **Axne (IA)** **S. 2493** **Bennet (CO)**	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency, whichever occurs later. Funds that are unspent by any deadline must be repaid to the U.S. Department of Health and Human Services (HHS). ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**07/28/2021** Introduced; referred to committees	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1914 **DeFazio (OR)** **S. 764** **Wyden (OR)**	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would allow State Medicaid programs to provide 24/7 community-based mobile crisis intervention services — under a State Plan Amendment or waiver — for those experiencing a mental health or substance use disorder crisis. Would provide states a 95% Federal Medical Assistance Percentage (FMAP) to cover such services for three years as well as a total of $25 million in planning grants. ***Potential CalOptima Impact:*** *Subject to further action by the California Department of Health Care Services (DHCS), increased behavioral health and substance use disorder services to CalOptima Medi-Cal members.*	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support
AB 552 **Quirk-Silva**	**Integrated School-Based Behavioral Health Partnership Program:** Would establish the Integrated School-Based Behavioral Health Partnership Program to expand prevention and early intervention behavioral health services for students. This would allow a county mental health agency and local education agency to develop a formal partnership whereby county mental health professionals would deliver brief school-based services to any student who has, or is at risk of developing, a behavioral health condition or substance use disorder. ***Potential CalOptima Impact:*** *Increased coordination with the Orange County Health Care Agency and school districts to ensure non-duplication of other school-based behavioral health services and initiatives.*	**01/11/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch

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COVERED BENEFITS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 56 **Biggs (AZ)**	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima's lines of business.*	**01/04/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 1118 **Dingell (MI)**	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**02/18/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4187 **Schrier (WA)**	**Medicare Vision Act of 2021:** Effective January 1, 2024, would require Medicare Part B coverage of vision services, including eyeglasses, contact lenses, routine eye examinations and fittings. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and Program of All-Inclusive Care for the Elderly (PACE).*	**06/25/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4311 **Doggett (TX)** **S. 2618** **Casey (PA)**	**Medicare Dental, Vision, and Hearing Benefit Act of 2021:** Effective no sooner than January 1, 2022, would require Medicare Part B coverage of the following benefits: ■ Dental: Routine dental cleanings and examinations, basic and major dental services, emergency dental care, and dentures ■ Vision: Routine eye examinations, eyeglasses, contact lenses and low vision devices ■ Hearing: Routine hearing examinations, hearing aids and related examinations The Senate version would also increase the Medicaid FMAP for hearing, vision and dental services to 90%. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE); higher federal funding rate for current Medi-Cal benefits.*	**07/01/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4650 **Kelly (IL)**	**Medicare Dental Coverage Act of 2021:** Effective January 1, 2025, would require Medicare Part B coverage of dental and oral health services, including routine dental cleanings and examinations, basic and major dental treatments, and dentures. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and Program of All-Inclusive Care for the Elderly (PACE).*	**07/22/2021** Introduced; referred to committees	CalOptima: Watch

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MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1738 **Dingell (MI)** **S. 646** **Brown (OH)**	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**03/10/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
H.R. 5610 **Bera (CA)** **S. 3001** **Van Hollen (MD)**	**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, 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 would be subject to a zero net premium. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**10/19/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
AB 1355 **Levine**	**Medi-Cal Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system for Medi-Cal managed care plans (MCPs), effective January 1, 2023. The bill would also provide every Medi-Cal beneficiary filing a grievance with access to an IMR. ***Potential CalOptima Impact:*** *Implementation of an additional grievance and appeals process for CalOptima Medi-Cal members.*	**01/11/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
AB 1400 **Kalra, Lee, Santiago**	**California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of CHIP, Medi-Cal, Medicare, the Knox-Keene Act, and ancillary health care or social services covered by regional centers for people with developmental disabilities. ***Potential CalOptima Impact:*** *Unknown but potentially significant impacts to the Medi-Cal delivery system and MCPs, including changes to administration, covered benefits, eligibility, enrollment, financing and organization.*	**01/11/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch CAHP: Oppose

OLDER ADULT SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4131 **Dingell (MI)** **S. 2210** **Casey (PA)**	**Better Jobs Better Care Act:** Would make permanent the enhanced 10% FMAP for Medicaid home- and community-based services (HCBS) enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Impact:*** *Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.*	**06/24/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4941 **Blumenauer (OR)**	**PACE Part D Choice Act of 2021:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Impact:*** *Increased enrollment into CalOptima PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.*	**08/06/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
S. 1162 **Casey (PA)**	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Impact:*** *Subject to further DHCS authorization, expanded eligibility for CalOptima PACE; additional federal funding to expand the service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to committee	CalOptima: Watch CalPACE: Support NPA: Support

SOCIAL DETERMINANTS OF HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 379 **Barragan (CA)** **S. 104** **Smith (MN)**	**Improving Social Determinants of Health Act of 2021:** Would require the Centers for Disease Control and Prevention (CDC) to establish a social determinants of health (SDOH) program to coordinate activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities, as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address SDOH.*	**01/21/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 943 **McBath (GA)** **S. 851** **Blumenthal (CT)**	**Social Determinants for Moms Act:** Would require HHS to convene a task force to coordinate federal efforts on social determinants of maternal health as well as award grants to address SDOH, eliminate disparities in maternal health and expand access to free childcare during pregnancy-related appointments. Would also extend postpartum eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children from six months postpartum to two years postpartum. ***Potential CalOptima Impact:*** *Additional federal guidance or requirements as well as increased availability of federal grants to address social factors affecting maternal health.*	**02/08/2021** Introduced; referred to committees	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2503 Bustos (IL)	**Social Determinants Accelerator Act of 2021:** Would establish the Social Determinants Accelerator Interagency Council to award state and local health agencies up to 25 competitive grants totaling no more than $25 million, as well as provide technical assistance to improve coordination of medical and non-medical services to a targeted population of high-need Medicaid beneficiaries. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address the SDOH of members with complex needs.*	**07/15/2021** Passed House Energy and Commerce Committee's Subcommittee on Health; referred to full Committee	CalOptima: Watch
H.R. 3894 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2021:** Would require the Centers for Medicare & Medicaid Services (CMS) to update guidance at least once every three years to help states address SDOH in Medicaid and CHIP programs. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**12/08/2021** Passed House floor; referred to Senate Committee on Finance	CalOptima: Watch
H.R. 4026 Burgess (TX)	**Social Determinants of Health Data Analysis Act of 2021:** Would require the Comptroller General of the United States to submit a report to Congress outlining the actions taken by HHS to address SDOH. The report would include an analysis of interagency efforts, barriers and potential duplication of efforts as well as recommendations on how to foster private-public partnerships to address SDOH. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**11/30/2021** Passed House floor; referred to Senate Committee on Health, Education, Labor, and Pensions	CalOptima: Watch

TELEHEALTH

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

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

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YOUTH SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 66 **Buchanan (FL)**	**Comprehensive Access to Robust Insurance Now Guaranteed (CARING) for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Impact:*** *Continuation of current federal funding and eligibility requirements for CalOptima Medi-Cal members eligible under CHIP.*	**01/04/2021** Introduced; referred to committee	CalOptima: Watch
H.R. 1390 **Wild (PA)** **S. 453** **Casey (PA)**	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *Increased federal funds for CalOptima Medi-Cal members eligible under CHIP.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed by both houses of the State Legislature in 2021. These are now considered two-year bills and are eligible for reconsideration in 2022:

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

Signed Bills

- H.R. 1868 (Yarmuth [KY])
- AB 128 (Ting)
- AB 133 (Committee on Budget)
- AB 161 (Ting)
- AB 164 (Ting)
- AB 361 (Rivas)
- AB 1082 (Waldron)
- SB 48 (Limón)
- SB 65 (Skinner)
- SB 129 (Skinner)
- SB 171 (Committee on Budget and Fiscal Review)
- SB 221 (Wiener)
- SB 306 (Pan)
- SB 510 (Pan)

Vetoed Bills

- AB 369 (Kamlager)
- AB 523 (Nazarian)
- SB 365 (Caballero)
- SB 682 (Rubio)

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

2022 Federal Legislative Dates

January 3	117th Congress, Second Session convenes
April 11–22	Spring recess
August 1–12	Summer recess for House
August 8–September 5	Summer recess for Senate
December 10	Second Session adjourns

2022 State Legislative Dates

January 3	Legislature reconvenes
February 18	Last day for legislation to be introduced
April 7–18	Spring recess
April 29	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in their house
May 6	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in their house
May 20	Last day for fiscal committees to hear and report to the floor any bills introduced in their house
May 23–27	Floor session only
May 27	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills to fiscal committees or the floor
July 1–August 1	Summer recess
August 12	Last day for fiscal committees to report bills to the floor
August 15–31	Floor session only
August 25	Last day to amend bills on the floor
August 31	Last day for bills to be passed; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2022 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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Board of Directors Meeting
February 3, 2022

CalOptima Community Outreach Summary — January and February 2022

Background

CalOptima is committed to serving the community by sharing information with current and potential members, and strengthening relationships with community partners. To do so, CalOptima attends community coalitions, collaborative meetings and advisory groups, and supports our community partners' public activities.

CalOptima's participation in public activities promotes:

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

CalOptima continues to participate in public activities virtually in most instances with some limited in-person attendance. Participation includes providing CalOptima Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima-branded items.

Community Outreach Highlight

CalOptima and the Orange County Healthcare Agency collaborated to host five COVID-19 vaccine events focused on children ages 5–11 years old and those ages 12 and over who are unvaccinated. These events are hosted in cities with the highest percentages of CalOptima members ages 5–11: Anaheim, Irvine, Garden Grove and Santa Ana. At the first three events, nearly 2,000 individuals were vaccinated and 560 Member Health Rewards distributed. Two events took place on January 15 and 22 at the County of Orange Social Services Agency Central Regional Office in Santa Ana where attendees also had the ability to learn about and enroll in CalFresh, CalWORKS and Medi-Cal. The events were widely promoted on CalOptima's social media outlets, via text messaging and Community Announcements to more than 2,700 community partners. CalOptima also hosted a resource table at these vaccine events to share information about CalOptima. These efforts aimed to increase vaccination rates among our members and build community partnerships.

Summary of Public Activities

As of January 7, CalOptima plans to participate in, organize or convene 47 public activities in January and February. In January, there will be 23 public activities: 18 virtual community/collaborative meetings, three community events, one community-based organization presentation and one Health Network Forum. In February, there will be 24 public activities: 17 virtual community/collaborative meetings, five community events, one Cafecito and one Health Network Forum. CalOptima's participation in community meetings throughout Orange County can be found in the attachment.

Endorsements

CalOptima provided zero endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

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

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List of community events hosted by community partners and CalOptima-hosted events and meetings in January and February 2022:

January 2022			
1/15 9 a.m.–3 p.m.	**Vaccine Event hosted by the County of Orange and CalOptima*** Orange County Social Services Agency Central Regional Office 2020 W. Walnut St., Santa Ana	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
1/19 9 a.m. – 2 p.m.	**Mobile Mammogram Clinic hosted by CalOptima and Alinea Medical Imaging*** St. Boniface Catholic Church 120 N. Janss St., Anaheim	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
1/20 9 a.m. –11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
1/22 9 a.m.–3 p.m.	**Vaccine Event hosted by the County of Orange and CalOptima*** Orange County Social Services Agency Central Regional Office 2020 W. Walnut St., Santa Ana	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
1/25 8 a.m. –9 a.m.	**CalOptima Medi-Cal English Presentation for the Orange Senior Center Roundtable** Orange Senior Center 170 S. Olive St., Orange	At least one staff member presented (in-person).	• Steering committee meeting • Open to collaborative members
1/26 1 p.m. – 2 p.m.	**InfoSeries: An Update on the CalAIM Launch*** Virtual	At least 10 staff members attended.	• Forum • Open to community stakeholders; register prior to event
February 2022			
02/05-02/06 10 a.m.–5 p.m.	**Tet Festival hosted by the Union of Vietnamese Students Association†** OC Fair and Event Center 88 Fair Dr., Costa Mesa	At least 16 staff members to attend (in-person). Sponsorship fee: $10,000; includes logo and link on website, resource table, banner display, color ad in event program book, speaking opportunity and 30-second video ad on main stage.	• Health/resource fair • Open to the public
02/05 10 a.m.–5 p.m.	**Tet Festival hosted by Viet America Society†** Mile Square Park 16801 Euclid St., Fountain Valley	At least 16 staff members to attend (in-person) Sponsorship fee: $10,000, includes resource table, three banner displays, twenty-five radio impressions, fifteen television impressions, full ad size, flyers distributed throughout the event, and two 8x8 back drop on festival stage.	• Health/resource fair • Open to the public
02/7–02/9 9 a.m.–4 p.m.	**26th Annual Conference hosted by Insure the Uninsured Project (ITUP)** Virtual	At least one staff member to attend. Sponsorship fee: $2,500; includes recognition as a general sponsor on the conference event page, ITUP website, and	• Conference • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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		conference marketing materials, such as social media and e-blast.	
2/17 9 a.m. –11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
2/19 9 a.m.–3 p.m.	**Vaccine Event hosted by the County of Orange and CalOptima*** Second Baptist Church 4300 Westminster Ave., Santa Ana	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public
2/23 9 a.m. –10:30 a.m.	**Cafecito Meeting *** Virtual	At least three staff members to attend.	• Steering committee meeting • Open to collaborative members

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, 2022
Special Meeting of the CalOptima Board of Directors

Report Item

15. Request to Ratify and Extend the Use of a Temporary Utilization Management Protocol for Referrals to University of California, Irvine Specialist Physicians through 2/28/2022

Contacts

Richard Helmer, Interim Chief Medical Officer, (714) 468-1100
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

1. Ratify past approval and authorize continuation of automatic approval of all CalOptima Direct (COD) and CalOptima Community Network (CCN) care referred to University of California, Irvine specialty physicians as support for a temporary solution for Prior Authorization timeliness and to increase access to care for requests received by CalOptima prior to February 28, 2022. The following services are excluded from this streamlined process:
   - Elective surgeries;
   - Kidney transplants;
   - Pediatric Services (to identify CCS-paneled provider reviews); and
2. Authorize unbudgeted expenditures in an amount up to **$376,000** from existing reserves to support the increased medical expenses associated with the temporary approval process change.

Background and Discussion

On July 10, 2008, CalOptima's Board of Directors approved the execution of a specialty physician contract with University of California, Irvine University Physicians & Surgeons (UCIUPS) for the provision of services to CalOptima Direct (COD) members. This action enabled CalOptima to manage the administrative authorization process and to establish contracted rates. One of the contract terms was that CalOptima would prior authorize and pay UCIUPS (i.e., tertiary care providers) when the covered, medically necessary services are not available through other contracted providers (i.e., community specialists). UCIUPS acknowledged in the contract that CalOptima intends to direct COD members to community specialty physicians when appropriate.

Currently, CalOptima has more than 97,000 COD members and 106,00 Medi-Cal Members in CCN that may leverage UCI physicians for specialty care when needed, which generates a large volume of specialty care requests that require timely decisions for members to access the right care, at the right time, and in the right setting.

This recommended action will reduce the volume of cases in active inventory that require manual case review. This will also allow the new clinical leadership team to fully address the cause of the backlog and ensure that new protocols are adopted, trained to, and overseen to meet inventory timeliness and compliance.

In order to maintain continued compliance with new inventory, management requests that the Board ratify the past approval and continue to authorize approval of all non-critical COD and CCN care

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requests referred to UCI specialist physicians, and received by CalOptima prior to February 28, 2022, as a temporary solution as further efficiencies and process improvements are implemented.

Fiscal Impact

The recommended action to ratify the past use of and authorization of the continued use of a temporary utilization management protocol for services to COD and CCN members referred to University of California, Irvine specialist physicians for requests received prior to February 28, 2022, is unbudgeted. Additional medical expenses associated with an increased authorization approval rate is estimated at $376,000. An appropriation of this amount from existing reserves would fund this action for the three-month review period.

Rationale for Recommendation

Staff respectfully requests ratification of this approach to referrals to UCI specialist physicians and the authorization to continue to approve all COD and CCN care referred to UCI specialist physicians received prior to February 28, 2022, as a temporary solution, with the above exceptions, to continue providing timely care for members and continued action to support our providers at the point of service. This ratification further supports permanent solutions to be implemented and overseen to ensure high quality and seamless care to our members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated July 10, 2008, Authorize the Chief Executive Officer to Execute a Specialty Physician Contract with UC Irvine Healthcare for the Provision of Services to CalOptima Direct Members

Board Action(s)

Board Meeting Dates	Action	Term	Not to Exceed Amount
July 10, 2008	To execute a specialty physician contract with UCI for the provision of services to COD members	Through June 30, 2010	$600,000 on an annual basis

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
University of California at Irvine Health (UCI Health) or UCI Medical Center	101 The City Drive South	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken July 10, 2008
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. A. Authorize the Chief Executive Officer to Execute a Specialty Physician Contract with UC Irvine Healthcare for the Provision of Services to CalOptima Direct Members

Contact
Gregory S. Buchert, MD, Chief Operating Officer, 714-246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, and subject to Department of Health Care Services' (DHCS) approval, to execute a specialty physician contract with UC Irvine Healthcare for the provision of services to CalOptima Direct members.

Background
CalOptima Direct (COD) has over 92,000 Medi-Cal members for which it provides services. The majority of these members are dual eligibles, having Medicare as the primary payer; others include members with share of cost requirements resulting in episodic coverage, transitional members that have COD to provide care until a member chooses a health network, and retroactive members. Approximately 10% of the members are continuous residents of COD. The continuous residents include foster children, residents of Fairview Developmental Center, members with certain diseases (e.g., end stage renal disease, hemophilia, transplant needs, breast and cervical cancer), and members that are seniors and persons with disabilities (SPD) who had been receiving care from the UCI Physician Hospital Consortia (UCI Health Network) consisting of UCI Medical Center (UCIMC) and UCI Physicians & Surgeons (UCIP&S).

Effective December 31, 2005, UCI terminated the UCI Health Network contractual arrangement with CalOptima. Effective January 1, 2006, Monarch Healthcare Medical Group and Garden Grove Hospital partnered to form the Monarch Garden Grove PHC and assumed care for members formerly enrolled in the UCI Health Network. At that time UCIMC and UCIP&S entered into a sub-capitated contract with the Monarch PHC. In September 2006, UCIMC and UCIP&S informed CalOptima that it would no longer accept financial risk for the SPD members, effective January 1, 2007. On October 19, 2006, the CalOptima Board approved the creation of an SPD Pilot Program and SPD members previously served by UCI were transitioned to CalOptima Direct. The Board authorized CalOptima staff to pursue an agreement with UCI to maintain continuity of care for SPD members.

CalOptima currently has a fee-for-service hospital contract with UCIMC which is effective through June 30, 2009. CalOptima does not, however, have a contract with UC Irvine

Healthcare, the entity formerly known as UCIP&S. In the absence of a contract, UCI Healthcare currently requires that CalOptima complete a Letter of Agreement (LOA) and provide prior written authorization for each episode of care for every member needing specialty physician services. To date, CalOptima has processed over 6,000 LOAs for these services, resulting in a significant increase in administrative resources in addition to the increased costs for medical care compared to average rates paid to other specialty physicians.

During the past six months, staff has worked to develop a network of contracted specialty physicians to whom many patients can be assigned. Due to the unique characteristics of the members in COD, however, it is anticipated that some COD members—both former members of the SPD Pilot Program and other COD members—will continue to receive services from UC Irvine Healthcare. In order to manage the administrative authorization process and to establish contracted rates, Staff recommends that CalOptima enter into a specialty physicians services contract with UC Irvine Healthcare.

Discussion

CalOptima and UC Irvine Healthcare have negotiated the terms of the specialty physicians contract for over a year and have now nearly reached agreement on a contract covering specialty physician services to COD members, subject to approval by the CalOptima Board of Directors and the Department of Health Care Services. The material terms of the contract are described below:

1. Term: The term of the contract is for approximately two (2) years (date of execution through June 30, 2010). The contract includes a ninety (90)-day without cause termination provision for both parties.

2. Compensation: The proposed UC Irvine Healthcare specialty physician contract covers rates for specialty physician services except plastic surgery, emergency services, and "By-report" items and services. The following emergency department procedure codes are excluded: 99281, 99282, 99283, 99284, 99285, 99291, and 99292. For plastic surgery, due to the limited number of plastic surgeons who see Medi-Cal members, CalOptima will negotiate rates with UC Irvine Healthcare plastic surgeons on case-by-case basis. For those limited covered and authorized "By-report" items and services which are defined as items and services with a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code that does not have a fee identified on the Medi-Cal fee schedule (e.g. CPT XXX99), CalOptima will negotiate a rate. The proposed contract includes compensation rates (inclusive of all the above services) that will, on an annual basis, result in aggregate annual payments that exceed the aggregate payments based on rates payable to non-contracted physicians for similar services by not more than $600,000.

CalOptima will prior authorize and pay UC Irvine Healthcare when the covered, medically necessary services are not available through other contracted providers. UC Irvine Healthcare acknowledges in the contract that CalOptima intends to direct COD members to community specialty physicians when appropriate.

3. Compliance Program Requirements: CalOptima contracts incorporate obligations for providers to comply with the Board-approved Compliance Program including CalOptima program policies. UC Irvine Healthcare is a public entity with independent compliance requirements imposed on it by the State and has a detailed corporate compliance program and internal policies and procedures. UC Irvine Healthcare has represented that its Compliance Program has been adopted by the UC Regents and approved by State and Federal regulatory agencies. The terms of the proposed contract will require UC Irvine Healthcare to follow and comply with its own Compliance Program requirements as well as CalOptima program policies relevant to the contract subject to approval of this provision by the Department of Health Care Services (DHCS). DHCS review of the proposed contract template is currently in progress.

4. Rate Adjustments: The contract includes a provision allowing UC Irvine Healthcare to terminate the contract upon thirty (30) days notice, in the event of rate adjustment provided the notice is given within thirty (30) days of receipt of CalOptima's notice of the rate adjustment.

Fiscal Impact
It is estimated that the additional cost to CalOptima as a result of contracting with UC Irvine Healthcare specialty physicians will be not more than $600,000 on an annual basis as described above. This cost is expected to decrease over time as staff transitions COD members away from UC Irvine Healthcare to other COD contracted specialists.

Rationale for Recommendation
CalOptima needs to contract with UC Irvine Healthcare for specialty physician services in order to manage the authorization process and establish contracted rates. The compensation paid under the contract will result in aggregate compensation that exceeds that which would be paid in the aggregate for non-contracted specialty physician services. While efforts to transition members to other contracted specialists are ongoing, there will continue to be COD members that require services from specialists in UC Irvine Healthcare. By entering into the proposed contract, CalOptima can secure slightly more favorable payment rates relative to those that are currently being paid, and also decrease current administrative burdens related to the LOA process to both CalOptima and UC Irvine Healthcare.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

Richard Chamberlain — 7/2/08

Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, ~~2021~~ 2022
Regular Meeting of the CalOptima Board of Directors

Rev. 2/3/2022

Report Item

16. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Ratify:

1. Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, contracted Medi-Cal fee-for-service (FFS) primary care, specialist and ancillary providers, for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal members on dates of service January 1, 2022, through June 30, 2022;
2. Extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels, for compliant, contracted Medi-Cal FFS behavioral health providers for services provided to all CalOptima Medi-Cal members on dates of service January 1, 2022, through June 30, 2022; and
3. Use of unbudgeted expenditures up to $8.3 million from existing reserves to provide funding for the recommended supplemental payment increases.

Background & Discussion

Staff requests that the CalOptima Board of Directors (Board) ratify an extension of a temporary, supplemental payment increase to FFS primary care, specialist, ancillary, and behavioral health providers for COVID-related expenses between January 1, 2022 and June 30, 2022, as well as use of unbudgeted reserve funds to support the increase.

In response to COVID-19, the Board, at its March 4, 2021, meeting, authorized a temporary, short-term supplemental increase of 5% to contracted CalOptima Medi-Cal providers for certain medically necessary services provided to CCN and COD-A members between January 1, 2021, and June 30, 2021. At its September 2, 2021, meeting, the Board authorized resuming the supplemental increase through December 31, 2021. The Board also expanded the payments for behavioral health providers to include services provided to all CalOptima Medi-Cal members, rather than only CCN and COD-A members.

The supplemental payment increase under consideration is intended to support providers in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members.

To continue supporting providers with COVID-related expenses and members' access to care, staff recommends ratifying extension of the temporary, short-term supplemental payment increase, excluding those services listed in Attachment 4, for dates of service January 1, 2022, through June 30, 2022. This

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action will help preserve the viability of CalOptima's Medi-Cal FFS provider network and strengthen members' access to care in anticipation of higher expense levels post-pandemic.

Fiscal Impact

The recommended action to ratify extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels for the period of January 1, 2022, through June 30, 2022, for compliant, contracted Medi-Cal FFS primary care, specialist, behavioral health, and ancillary providers is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $5.6 million for the six-month period. The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS behavioral health providers is approximately $2.7 million. An allocation of up to $8.3 million from existing reserves would fund these actions.

Rationale for Recommendation

Ratifying extension of the temporary, COVID-related supplemental payment increase for contracted CCN and COD Medi-Cal FFS providers will preserve the viability of CalOptima's provider network, strengthen members' access to care and support the safety net system serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 2, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers due to COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members
2. Board Action Dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses
3. Board Action Dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses
4. Services Excluded from Temporary Increase

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

14. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers due to COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize resuming a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist and Ancillary Providers, for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Members on dates of service September 1, 2021, through December 31, 2021;
2. Authorize resuming a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted Medi-Cal FFS Behavioral Health Providers to include all CalOptima Medi-Cal members; and
3. Authorize unbudgeted expenditures up to $5.5 million from existing reserves to provide funding for the recommended supplemental payment 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its March 4, 2021, meeting, the Board authorized a short-term supplemental increase of 5% from current levels to contracted CalOptima Medi-Cal primary care, specialist, behavioral health and ancillary providers for certain medically necessary services provided to CCN and COD-A members between January 1, 2021, and June 30, 2021.

Discussion

Management recognizes that the coronavirus pandemic continues to place significant stress on the healthcare providers and delivery system serving CalOptima members. In late June, the Centers for Disease Control and Prevention (CDC) issued new guidance and data related to the more contagious Delta variant. Orange County has experienced a surge of Delta variant cases leading to increased hospitalizations and strain on health care resources.

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In mid-July, the California Department of Health Care Services (DHCS) released its Medi-Cal COVID-19 Vaccine Incentive Program. This program will use $350 million dollars statewide to improve the vaccination rates among Medi-Cal beneficiaries. The focus populations include members who:

1. Are homebound and unable to travel to vaccination sites;
2. Are 50-64 years of age with multiple chronic diseases;
3. Self-identify as persons of color; and
4. With the return to school, are youth 12-25 years old.

This additional funding will assist providers to address the latest surge in Delta variant cases and to help improve vaccination rates for CalOptima's members by promoting an increase in vaccinations within the Medi-Cal focus populations, consistent with DHCS's COVID-19 vaccination strategy.

The prior supplemental payments to behavioral health provides included medically necessary services provided only to CCN and COD-A members. This recommended action is to expand these supplemental payments to behavioral health to include all CalOptima Medi-Cal members.

In recognition of the demands the pandemic has placed on providers, providing the supplemental payment increase for the referenced period for medically necessary Medi-Cal services, is recommended. The increase will help preserve the viability of CalOptima's Medi-Cal FFS provider network, and strengthen access to care in light of the higher utilization levels, including COVID-19-related treatment.

Staff recommends that the Board approve a resumption of the temporary, supplemental 5% increase for providers, excluding those services listed in Attachment 3, and necessary unbudgeted expenditures to implement this increase for dates of service from September 1, 2021, through December 31, 2021.

Fiscal Impact

The recommended action to authorize resuming a temporary, short-term supplemental payment increase of 5% from current levels for the period of September 1, 2021, through December 31, 2021, for compliant, contracted Medi-Cal FFS primary care, specialist, behavioral health and ancillary providers is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $3.7 million for the four-month period. The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS behavioral health providers is approximately $1.8 million. An allocation of up to $5.5 million from existing reserves will fund these actions.

As of this writing, DHCS has not released detailed guidance on their Medi-Cal COVID-19 Vaccine Incentive Program. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation

Resuming the temporary, PHE-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS providers is intended to ensure the viability of CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses
2. Board Action Dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses
3. Services Excluded from Temporary Increase

/s/ Richard Sanchez — *08/26/2021*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

24. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and

2. Authorize the additional 5% in unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support CalOptima's Medi-Cal FFS providers and strengthen access to care,

given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS providers is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

23. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted to Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental Medi-Cal payment increase of 5% from current levels to certain Providers affiliated with Providence St. Joseph Heritage Healthcare for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and
2. Authorize the additional 5% unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for certain providers affiliated with Providence St. Joseph Heritage Healthcare is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support certain providers affiliated with Providence St. Joseph Heritage Healthcare and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for

other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to certain providers affiliated with Providence St. Joseph Heritage Healthcare for identified services through the claims payment system. Staff will give notice to certain providers affiliated with Providence St. Joseph Heritage Healthcare of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to certain providers affiliated with Providence St. Joseph Heritage Healthcare monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels to certain providers affiliated with Providence St. Joseph Heritage Healthcare is an unbudgeted item.

The projected aggregated fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal fee-for-service providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for St. Joseph Heritage Healthcare is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthen access to member care and support the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services Excluded from Temporary, Short-Term Supplemental Payment Increase

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

24. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and

2. Authorize the additional 5% in unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support CalOptima's Medi-Cal FFS providers and strengthen access to care,

given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS providers is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez — *02/24/2021*
Authorized Signature — **Date**

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

23. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted to Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental Medi-Cal payment increase of 5% from current levels to certain Providers affiliated with Providence St. Joseph Heritage Healthcare for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and
2. Authorize the additional 5% unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for certain providers affiliated with Providence St. Joseph Heritage Healthcare is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support certain providers affiliated with Providence St. Joseph Heritage Healthcare and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for

other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to certain providers affiliated with Providence St. Joseph Heritage Healthcare for identified services through the claims payment system. Staff will give notice to certain providers affiliated with Providence St. Joseph Heritage Healthcare of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to certain providers affiliated with Providence St. Joseph Heritage Healthcare monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels to certain providers affiliated with Providence St. Joseph Heritage Healthcare is an unbudgeted item.

The projected aggregated fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal fee-for-service providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for St. Joseph Heritage Healthcare is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthen access to member care and support the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, ~~2021~~ 2022
Regular Meeting of the CalOptima Board of Directors

Rev. 2/3/2022

Report Item

17. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Ratify:

1. Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, contracted CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided to CalOptima CCN and COD-A Medi-Cal members on dates of service January 1, 2022, through June 30, 2022; and
2. Use of unbudgeted expenditures up to $240,000 from existing reserves to provide funding for the recommended supplemental payment increases.

Background & Discussion

Staff requests the CalOptima Board of Directors (Board) ratify both an extension of a temporary, supplemental payment increase to FFS Community Health Centers for COVID-related expenses between January 1, 2022, through June 30, 2022, as well as use of unbudgeted reserve funds to support the increase.

In response to COVID-19, the Board, at its February 4, 2021, meeting, authorized a temporary, short-term supplemental payment increase of 5% to contracted CCN and COD-A Medi-Cal FFS community health centers for certain medically necessary services provided between January 1, 2021, and June 30, 2021. At its September 2, 2021, meeting, the Board authorized resuming the increase through December 31, 2021.

The supplemental payment increase under consideration is intended to support providers, in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members.

To continue supporting providers with COVID-related expenses and members' access to care, staff recommends ratifying the supplemental payment increase, excluding those services listed in Attachment 3, for dates of service January 1, 2022, through June 30, 2022.

Fiscal Impact

The recommended action to ratify extension of a temporary, short term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels for the period of January 1, 2022, through

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June 30, 2022, for compliant, contracted CCN and COD-A Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $240,000 for the six-month period and will be funded from existing reserves.

Rationale for Recommendation

Ratifying extension of the temporary, COVID-related supplemental payment increase for contracted CCN and COD-A Medi-Cal Fee-for-Service community health centers will preserve the viability of CalOptima's provider network, strengthen members' access to care and support Orange County's safety net system serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses
2. Board Action Dated September 2, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal Fee-for-Service Community Health Centers due to COVID-19-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members
3. Services Excluded from Temporary Increase

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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CalOptima Board Action Agenda Referral

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

Report Item

21. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses

Contact

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided on dates of service January 1, 2021, through June 30, 2021; and

2. Authorize unbudgeted expenditures up to $210,000 to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for services provided by CCN and COD-A Medi-Cal FFS Community Health Centers during the period of January 1, 2021 through June 30, 2021. The increase is intended to support CalOptima's FFS Medi-Cal providers and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

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This item applies solely to CalOptima's Community Health Centers—including Federally Qualified Health Centers (FQHC), FQHC look alike clinics, and community clinics—which are an important part of the safety net serving CalOptima members. They provide increased access to care for CalOptima's various member populations, including the homeless, by reducing barriers such as language, distance, and wait time. In addition to the variety of primary, preventive, and health education services they provide, Community Health Centers have a direct impact in preventing the spread of COVID-19 throughout the community by providing COVID-19 testing and treatment. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers of the 5% increase following Board approval. Staff proposes making supplemental payment increases for dates of service beginning January 1, 2021 in February 2021. Adjudicated and paid claims for dates of service January 1, 2021, up until the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the covered service claim line level that, at a minimum, identifies the eligible date of service, covered billing service code and payment amount. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified eligible claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $210,000 for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is intended to ensure the viability of CalOptima's FFS Medi-

Cal clinic providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. List of Exclusions for Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

15. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal Fee-for-Service Community Health Centers due to COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

Contacts

Nancy Huang, Chief Financial Officer (657) 235-6935
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Actions

1. Authorize resuming a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal members on dates of service from September 1, 2021 through December 31, 2021; and
2. Authorize unbudgeted expenditures up to $150,000 from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers.

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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its February 4, 2021, meeting, the Board authorized a temporary, short-term supplemental payment increase of 5% from current levels to contracted CCN and COD Medi-Cal FFS community health centers for certain medically necessary services provided between January 1, 2021, and June 30, 2021.

Discussion

Management recognizes that the coronavirus pandemic continues to place significant stress on the healthcare providers and delivery system serving CalOptima members. In late June, the Centers for Disease Control and Prevention (CDC) issued new guidance and data related to the more contagious Delta variant. Orange County has experienced a surge of Delta variant cases leading to increased hospitalizations and strain on health care resources. In addition, the demand for coronavirus testing is expected to increase as children return to school in the fall. This will be especially true for certain age groups who are not currently eligible to receive the vaccine.

In mid-July, the California Department of Health Care Services (DHCS) released its Medi-Cal COVID-19 Vaccine Incentive Program. This program will use $350 million dollars statewide to

improve the vaccination rates among Medi-Cal beneficiaries. The focus populations include members who:

1. Are homebound and unable to travel to vaccination sites;
2. Are 50-64 years of age with multiple chronic diseases;
3. Self-identify as persons of color; and
4. With the return to school, are youth 12-25 years old.

The rate increase recommendation is intended to utilize and support providers in improving vaccination rates for CalOptima's members, consistent with DHCS's COVID-19 vaccination strategy. Pending additional guidance from DHCS, community health centers are expected to participate in the COVID-19 incentive program that CalOptima will develop. This additional funding will assist providers in addressing the latest surge in Delta variant cases and projected increase in demand for coronavirus testing, and to promote an increase in vaccinations within the Medi-Cal focus populations identified by DHCS.

In recognition of the demands the pandemic has placed on community health centers, providing the supplemental payment increase for the referenced period for medically necessary Medi-Cal services is recommended. The increase will help preserve the viability of CalOptima's Medi-Cal FFS community health centers and strengthen access to care in light of the higher utilization levels including COVID-19-related testing and treatment.

Staff recommends approving the temporary, supplemental 5% increase for providers, excluding those services listed in Attachment 2, and necessary unbudgeted expenditures to implement this increase for dates of service September 1, 2021 through December 31, 2021.

Fiscal Impact

The recommended action to authorize resuming a temporary, short term supplemental payment increase of 5% from current levels for the period of September 1, 2021 through December 31, 2021 for compliant, contracted Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $150,000 for the four-month period and will be funded from existing reserves.

As of this writing, DHCS has not released detailed guidance on their Medi-Cal COVID-19 Vaccine Incentive Program. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation

The temporary, PHE-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS Community Health Centers ensures the viability of CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports Orange County's safety net system during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses
2. Services Excluded from Temporary Increase

/s/ Richard Sanchez *08/25/2021*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

21. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses

Contact

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided on dates of service January 1, 2021, through June 30, 2021; and

2. Authorize unbudgeted expenditures up to $210,000 to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for services provided by CCN and COD-A Medi-Cal FFS Community Health Centers during the period of January 1, 2021 through June 30, 2021. The increase is intended to support CalOptima's FFS Medi-Cal providers and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

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This item applies solely to CalOptima's Community Health Centers—including Federally Qualified Health Centers (FQHC), FQHC look alike clinics, and community clinics—which are an important part of the safety net serving CalOptima members. They provide increased access to care for CalOptima's various member populations, including the homeless, by reducing barriers such as language, distance, and wait time. In addition to the variety of primary, preventive, and health education services they provide, Community Health Centers have a direct impact in preventing the spread of COVID-19 throughout the community by providing COVID-19 testing and treatment. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers of the 5% increase following Board approval. Staff proposes making supplemental payment increases for dates of service beginning January 1, 2021 in February 2021. Adjudicated and paid claims for dates of service January 1, 2021, up until the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the covered service claim line level that, at a minimum, identifies the eligible date of service, covered billing service code and payment amount. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified eligible claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $210,000 for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is intended to ensure the viability of CalOptima's FFS Medi-

Cal clinic providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. List of Exclusions for Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, ~~2021~~ 2022
Regular Meeting of the CalOptima Board of Directors

Rev. 2/3/2022

Report Item

18. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Hospitals, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Ratify:

1. Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Hospitals, for certain medically necessary services provided to CCN and COD-A Medi-Cal members for dates of service January 1, 2022, through June 30, 2022; and
2. Use of unbudgeted expenditures up to $5.5 million from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals

Background & Discussion

Staff requests the CalOptima Board of Directors (Board) ratify both an extension of a temporary, supplemental payment increase to FFS Hospitals for COVID-related expenses between January 1, 2022, through June 30, 2022, as well as use of unbudgeted reserve funds to support the increase.

In response to COVID-19, the Board, at its February 4, 2021, meeting, authorized a temporary, short-term supplemental payment increase of 5% to contracted CCN and COD-A Medi-Cal FFS Hospitals for certain medically necessary services through June 30, 2021. The Board also authorized additional increased compensation to Long Term Acute Care Hospitals (LTAC) for authorized inpatient services provided to CalOptima members through June 30, 2021. At its September 2, 2021, meeting, the Board authorized resuming the supplemental increase through December 31, 2021.

The supplemental payment increase under consideration is intended to support providers in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services to our members.

To continue supporting providers with COVID-related expenses and members' access to care, staff recommends ratifying extension of the supplemental payment increase, excluding those services listed in Attachment 4, for dates of service January 1, 2022, through June 30, 2022.

Fiscal Impact

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The recommended action to ratify extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels for the period of January 1, 2022, through June 30, 2022, for CCN and COD-A Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $5.5 million for the six-month period and will be funded from existing reserves.

Rationale for Recommendation

Ratifying the temporary, COVID-related supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS Hospitals will preserve the viability of CalOptima's Medi-Cal FFS hospitals, strengthen members' access care and support Orange County's safety net system serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action Dated September 2, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal Fee-for-Service Hospitals due to COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members
3. Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-
   19-Related Expenses
4. Services Excluded from Temporary Increase

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	92780
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Beverly Hospital	309 W Beverly Blvd	Montebello	CA	90640
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
CHOC Children's at Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Childrens Hospital of Los Angeles	4650 W Sunset Blvd	Los Angeles	CA	90027
Children's Hospital of Orange County	1201 W La Veta Ave	Orange	CA	92868
Encompass Health Rehabilitation Hospital of Tustin	14851 Yorba St	Tustin	CA	92780
Fountain Valley Regional Hospital & Medical Center	17100 Euclid St	Fountain Valley	CA	92708
HealthBridge Children's Hospital - Orange	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	92663
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital Regional Medical Ctr	27700 Medical Center Rd	Mission Viejo	CA	92691
Orange Coast Memorial Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 N Rose Dr	Placentia	CA	92870
Pomona Valley Hospital Medical Center	1798 N Garey Ave	Pomona	CA	91767
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Garden Grove Hospital Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	92843
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
La Palma Intercommunity Hospital	7901 Walker St	La Palma	CA	90623
UCI Medical Center	101 The City Dr South	Orange	CA	92868
Saddleback Memorial Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Providence St Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

16 Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal Fee-for-Service Hospitals due to COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize resuming a temporary, short-term supplemental payment increase of 5% from current levels, for claims for members associated with compliant, contracted Medi-Cal Fee-for-Service (FFS) Hospitals for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal members between September 1, 2021 and December 31, 2021; and
2. Authorize unbudgeted expenditures up to $3.6 million from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals

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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its February 4, 2021, meeting, the Board authorized a short-term supplemental increase of 5% from current levels to contracted CCN and COD-A Medi-Cal FFS Hospitals for certain medically necessary services provided between January 1, 2021, and June 30, 2021. The Board authorized additional increased compensation to Long Term Acute Care Hospitals (LTAC) for authorized inpatient services provided to CalOptima Members, setting reimbursement at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, through June 30, 2021.

Discussion

Management recognizes that the coronavirus pandemic continues to place significant stress on healthcare providers and delivery system serving CalOptima members. In late June, the Centers for Disease Control and Prevention (CDC) issued new guidance and data related to the more contagious Delta variant. Orange County has experienced a surge of Delta variant cases leading to increased hospitalizations and strain on health care resources.

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In mid-July, the California Department of Health Care Services (DHCS) released its Medi-Cal COVID-19 Vaccine Incentive Program. This program will use $350 million dollars statewide to improve the vaccination rates among Medi-Cal beneficiaries. The focus populations include members who:

1. Are homebound and unable to travel to vaccination sites;
2. Are 50-64 years of age with multiple chronic diseases;
3. Self-identify as persons of color; and
4. With the return to school, are youth 12-25 years old.

This additional funding will assist hospitals in addressing the latest surge in Delta variant cases, and help improve vaccination rates for CalOptima members by promoting an increase in vaccinations within the Medi-Cal focus populations identified by DHCS.

In recognition of the demands the pandemic has placed on hospitals, providing the supplemental payment increase for the referenced period for claims of CCN and COD-A Medi-Cal members, for medically necessary Medi-Cal services is recommended. The increase will help preserve the viability of CalOptima's FFS Medi-Cal hospitals, and strengthen access to care in light of the higher utilization levels including COVID-19-related treatment.

Staff recommends approving the temporary, supplemental 5% increase, excluding those services listed in Attachment 3, and necessary unbudgeted expenditures to implement this increase for dates of service September 1, 2021, through December 31, 2021.

Fiscal Impact

The recommended action to authorize resuming a temporary, short-term supplemental payment increase of 5% from current levels for the period of September 1, 2021, through December 31, 2021, for claims of members associated with compliant, contracted Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $3.6 million for the four-month period and will be funded from existing reserves.

As of this writing, DHCS has not released detailed guidance on their Medi-Cal COVID-19 Vaccine Incentive Program. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation

Resuming the temporary, PHE-related supplemental payment is intended to ensure the viability of contracted CCN and COD-A Medi-Cal FFS Hospitals, and strengthens access for member care and supports the Orange County's hospital care delivery system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19-Related Expenses
3. Services Excluded from Temporary Increase

/s/ Richard Sanchez *08/25/2021*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	92780
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Beverly Hospital	309 W Beverly Blvd	Montebello	CA	90640
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
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Childrens Hospital of Los Angeles	4650 W Sunset Blvd	Los Angeles	CA	90027
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Encompass Health Rehabilitation Hospital of Tustin	14851 Yorba St	Tustin	CA	92780
Fountain Valley Regional Hospital & Medical Center	17100 Euclid St	Fountain Valley	CA	92708
HealthBridge Children's Hospital - Orange	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	92663
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital Regional Medical Ctr	27700 Medical Center Rd	Mission Viejo	CA	92691
Orange Coast Memorial Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 N Rose Dr	Placentia	CA	92870
Pomona Valley Hospital Medical Center	1798 N Garey Ave	Pomona	CA	91767
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Garden Grove Hospital Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	92843
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UCI Medical Center	101 The City Dr South	Orange	CA	92868
Saddleback Memorial Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
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Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

20. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19 Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive, Director Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant contracted CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal Fee-for-Service (FFS) Hospitals for certain medically necessary services provided on dates of service January 1, 2021 through June 30, 2021;

2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend contracts with Long Term Acute Care Hospitals (LTAC) to increase compensation for authorized inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 Public Health Emergency (PHE). The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021; and

3. Authorize unbudgeted expenditures up to $5.0 million to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

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Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on hospitals, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS hospitals is recommended. CalOptima's recommends that the Board approve a supplemental payment increase for contracted Medi-Cal FFS hospitals on qualifying claims during the period of January 1, 2021, through June 30, 2021. This increase is intended to support CalOptima's contracted hospitals for covered services, for a limited period. The increase is intended to support CalOptima's Medi-Cal FFS hospitals and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

This item applies solely to CalOptima's contracted hospitals, including LTAC hospitals, which play a key role in treating members infected with COVID-19, and preventing the spread of COVID-19 throughout the community. Long Term Acute Care Hospitals are acute care hospitals designed for patients requiring inpatient care for an extended period of time. Admitting access to LTAC hospitals has been a key concern for members who require longer term hospital care. CalOptima's reimbursement for LTAC services falls into two levels of care: "LTAC," for which CalOptima pays a higher acute level reimbursement rate, and "chronic maintenance," a level of care that is reimbursed at a lower rate. To ensure member access to LTACs during this public health emergency, staff recommends amending contracts with LTAC hospitals to increase compensation for authorized Medi-Cal inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 PHE. The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021. This will be in addition to the 5% supplemental payment increase, for all authorized services for members in these facilities. Contractual billing and authorization requirements will remain in place; however, the LTAC reimbursement rate will be applied during this temporary period. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the 5% supplemental payment increase will be administered to eligible hospitals for identified services through the claims payment system. Staff will provide notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in February 2021. Adjudicated and paid claims for dates of service between January 1, 2021, and the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the claim line level that, at a minimum, identify the eligible date of service, covered billing service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible hospitals monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims,

timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $5.0 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment is intended to ensure the viability of CalOptima's FFS Medi-Cal contracted hospitals, strengthens access for member care and supports the Orange County's hospital care delivery system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. List of Exclusions from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

20. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19 Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive, Director Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant contracted CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal Fee-for-Service (FFS) Hospitals for certain medically necessary services provided on dates of service January 1, 2021 through June 30, 2021;

2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend contracts with Long Term Acute Care Hospitals (LTAC) to increase compensation for authorized inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 Public Health Emergency (PHE). The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021; and

3. Authorize unbudgeted expenditures up to $5.0 million to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency 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 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

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Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on hospitals, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS hospitals is recommended. CalOptima's recommends that the Board approve a supplemental payment increase for contracted Medi-Cal FFS hospitals on qualifying claims during the period of January 1, 2021, through June 30, 2021. This increase is intended to support CalOptima's contracted hospitals for covered services, for a limited period. The increase is intended to support CalOptima's Medi-Cal FFS hospitals and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

This item applies solely to CalOptima's contracted hospitals, including LTAC hospitals, which play a key role in treating members infected with COVID-19, and preventing the spread of COVID-19 throughout the community. Long Term Acute Care Hospitals are acute care hospitals designed for patients requiring inpatient care for an extended period of time. Admitting access to LTAC hospitals has been a key concern for members who require longer term hospital care. CalOptima's reimbursement for LTAC services falls into two levels of care: "LTAC," for which CalOptima pays a higher acute level reimbursement rate, and "chronic maintenance," a level of care that is reimbursed at a lower rate. To ensure member access to LTACs during this public health emergency, staff recommends amending contracts with LTAC hospitals to increase compensation for authorized Medi-Cal inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 PHE. The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021. This will be in addition to the 5% supplemental payment increase, for all authorized services for members in these facilities. Contractual billing and authorization requirements will remain in place; however, the LTAC reimbursement rate will be applied during this temporary period. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the 5% supplemental payment increase will be administered to eligible hospitals for identified services through the claims payment system. Staff will provide notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in February 2021. Adjudicated and paid claims for dates of service between January 1, 2021, and the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the claim line level that, at a minimum, identify the eligible date of service, covered billing service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible hospitals monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims,

timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $5.0 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment is intended to ensure the viability of CalOptima's FFS Medi-Cal contracted hospitals, strengthens access for member care and supports the Orange County's hospital care delivery system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. List of Exclusions from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

19. Authorize Amendments to the CalOptima Community Network Professional Services Contracts to Add OneCare as a Covered CalOptima Program

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Action

Authorize amendment to the CalOptima Community Network (CCN) Professional Services Contracts to add OneCare as a covered CalOptima program, effective January 1, 2023.

Background & Discussion

Staff requests that the CalOptima Board of Directors (Board) authorize amending the CCN Professional Services Contracts to add OneCare as a covered program, effective January 1, 2023.

In 2014, the California Department of Health Care Services (DHCS) launched the Cal MediConnect (CMC) pilot to coordinate delivery of medical, behavioral health, long-term care, and home- and community-based services and integrate Medi-Cal and Medicare benefits for dual eligible beneficiaries into a single delivery system.

CalOptima participates in CMC via OneCare Connect (OCC), which was implemented on July 1, 2015. CMC was extended past its original termination date of December 31, 2017 but is now scheduled to end on December 31, 2022. As the CMC pilot winds down, OCC members will transition into OneCare (CalOptima's Dual Eligible Special Needs Plan) on January 1, 2023.

CCN providers are not currently contracted to provide services to OneCare members. For a seamless member transition and to minimize any potential disruption to members' access to care, staff is recommending amending the CCN provider agreements to include OneCare participation beginning in CY 2023.

To ensure continuity of care for OCC members as Cal MediConnect sunsets, staff requests the Board authorize amending the CCN Professional Services Contract to add OneCare as a covered program, effective January 1, 2023

Fiscal Impact

The recommended action to add OneCare to the scope of the existing professional services contracts is operational in nature, with no additional fiscal impact anticipated during the current fiscal year. Management will include medical and administrative expenses associated with these actions to support member transition to OneCare in the CalOptima Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

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Amending the CCN contracts to cover OneCare will ensure that CalOptima OCC members have a comprehensive OneCare provider network to provide a seamless transition of care for CalOptima members currently participating in OneCare Connect.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Presentation: 2021-09-02 Board Meeting OneCare Connect Transition.pptx
2. CMC 3-way Contract with CMS and DHCS: 2019.10.9_CA 3-Way Contract-H8016 CalOptima-Final Eff. 9-1-19 to 12-31-2022
3. CalAIM-Proposal-03-23-2021
4. CCN OneCare Amendment

/s/ Michael Hunn *01/27/2022*

Authorized Signature **Date**

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Better. Together.

OneCare Connect (OCC) Transition

Board of Directors Meeting
September 2, 2021

Ladan Khamseh, Chief Operating Officer
Ravina Hui, Director, Program Implementation (Medicare)

Background

- On April 1, 2014, the Department of Health Care Services (DHCS) implemented the Coordinated Care Initiative (CCI)
  - Introduced Cal MediConnect (CMC) duals demonstration
    - Coordinated delivery of medical, behavioral health, long-term care, and home- and community-based services
    - Delivered coordinated Medi-Cal and Medicare benefits in a single delivery system

Background (cont.)

- On July 1, 2015, CalOptima implemented OneCare Connect (OCC) Cal MediConnect Plan (Medicare-Medicaid Plan)
  - Based on three-way contract between the Centers for Medicare & Medicaid Services (CMS), DHCS and CalOptima
  - Qualified OneCare members cross-walked into OCC
    - OneCare program retained for duals who didn't qualify for OCC

Background (cont.)

- CMC demonstration period
  - Initially set to end December 31, 2017
  - CalOptima received state and federal authority for several CMC extensions
    - Three-way contract amended
      - January 1, 2018, demonstration year (DY) extended through December 31, 2019
      - September 1, 2019, DY extended through December 31, 2022
  - CMC will sunset on December 31, 2022

Member Transition

- CalOptima received state and federal authority to transition current OCC members into the OneCare Program
  - Via CalAIM legislation
  - Proposes enrollment of CMC plan to a Dual Eligible Special Needs Plan (D-SNP) managed by the same parent organization
    - OCC members will be cross-walked into OneCare on January 1, 2023

2023 Anticipated OneCare Provider Network

- Offer the same provider network options between OCC and OneCare
  - Supports seamless member transition
  - Minimizes disruption to member's access to care
- Expect all existing OCC health networks to participate in OneCare, including CalOptima Community Network (CCN)
  - Consistent with the current OC risk arrangement, OCC full risk health networks will transition to shared risk model
  - Provides better program viability for health networks and CalOptima

Current Health Network Participation

2021 OneCare Connect Health Networks	2021 OneCare Participation	2023 Anticipated OneCare Participation (as Shared Risk)
AltaMed Health Services Corporation	Participating	Participating
AMVI Care Health Network, Inc.*	Participating as AMVI/ Prospect Medical Group, a California general partnership between AMVI/IMC Health Network, Inc., a Medical Corporation and Santa Ana/Tustin Physician's Group, Inc.	Participating as AMVI Care Health Network, Inc.
Prospect Health Plan*		Participating as Prospect Medical Group, Inc.
Arta Western California Inc.	Participating	Participating
CalOptima Community Network	Not participating	Participating
Family Choice Medical Group, Inc.	Participating	Participating
Heritage Provider Network, Inc.*	Not participating	Participating
Monarch Health Plan Inc.*	Participating as Monarch Healthcare, a Medical Group, Inc.	Participating as Monarch Healthcare, a Medical Group, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	Participating	Participating
Talbert Medical Group, P.C.	Participating	Participating
United Care Medical Group, Inc.	Participating	Participating

*OCC Full Risk Health Networks

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Next Steps

Deliverables	Time Frame
Request Board authority to extend OneCare contracts to OCC health networks and amend the CCN provider contracts to include OneCare	• December 2021 Board (CCN) • May 2022 Board (health networks)
Release contracts to health networks and CCN providers	• January 2022 (CCN) • May 2022 (health networks)
Contract execution by OneCare health networks and CCN providers (effectuated in CY 2023)	• No later than May 31, 2022
Conduct readiness assessment for health networks transitioning to OneCare	• Q4 2022
OneCare Connect sunsets with members transitioning to OneCare	• January 1, 2023

Our Mission

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

Contract

Between

United States Department of Health and Human Services
Centers for Medicare & Medicaid Services

In Partnership with

California Department of Health Care Services

and

Orange County Health Authority

Effective: September 1, 2019

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This Contract, effective September 1, 2019 is between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the state of California, acting by and through the Department of Health Care Services (DHCS) and Orange County Health Authority (the Contractor). The Contractor's principal place of business is 505 City Parkway West, Orange, CA 92868.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, DHCS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq and California Welfare and Institutions Code § 14000 et seq, designed to work closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income and persons with disabilities;

WHEREAS, a purpose of this Contract is to test a new model of payment and service delivery pursuant to 1115A of the Social Security Act;

WHEREAS, the Contractor is in the business of ensuring access to care needed to improve health and quality of life, and CMS and DHCS desire to purchase services from the Contractor to offer quality, accessible care; improve care coordination among medical care, behavioral health, and long-term services and supports; and further the goals of the *Olmstead* Decision;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and state laws and regulations;

WHEREAS, this Contract replaces in its entirety, the Contracted entered into by CMS , DHCS, and the Contractor executed December 18, 2013 and re-executed on January 1, 2018, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract, but that were not imposed upon the Contractor either in the original version of this Contract executed on December 18, 2013, as amended, or under applicable laws or regulations, shall be prospective in nature only (effective September 1, 2019).

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

1. Definition of Terms

1.1. **Actual Non-Service Expenditures –** The Contractor's actual amount incurred for non-service expenditures, including both administrative and care management costs, for Enrollees during each Demonstration Year. These costs will exclude costs incurred by the Contractor prior to the start of the Demonstration. Any reinsurance costs reflected here will be net reinsurance costs.

1.2. **Actual Service Expenditures –** The Contractor's actual amount paid for Covered Services (as defined in Appendix A) delivered during each Demonstration Year. Actual Service Expenditures shall be priced at the Contractor fee level and should include all payments to providers for Covered Services, including pay-for-performance payments, risk-sharing arrangements, or sub-capitation payments.

1.3. **Adjusted Final Capitation Rate Revenue –** The Adjusted Interim Capitation Rate Revenue with the Minimum Savings Percentages, rather than the County-Specific Interim Savings Percentages, applied. This is determined by multiplying the Adjusted Interim Capitation Rate Revenue by (1- the Minimum Savings Percentage) / (1- the County-Specific Interim Savings Percentage).

1.4. **Adjusted Interim Capitation Rate Revenue –** The Total Capitation Rate Revenue excluding the monthly capitation payments for Medicare Part D services, and any risk adjustment or reconciliation associated with Medicare Part D payments.

1.5. **Adjusted Non-Service Expenditures –** The Contractor's Actual Non-Service Expenditures, adjusted to reflect the following:
-At the discretion of the State and CMS, exclusion of any costs, including care management, associated with Medicare Part D services as identified in CMS bid instructions and other guidance;
- Exclusion of costs greater than one hundred twenty five percent (125%) of the median cost per member per month across all participating Contractors during the Demonstration Year. Consideration will be given to any Contractor with significant non-typical membership mixes that may cause this exclusion to come into effect;
- Exclusion of reinsurance costs (net of reinsurance premiums); and
- Adjustments resulting from CMS and the State's review of the Contractor's

non-service expenditures to address any inappropriate or excessive non-service expenditures (including executive compensation and stop loss expenditures).

1.6. **Adjusted Service Expenditures –** The Contractor's Actual Service Expenditures, adjusted to reflect the following:
- Exclusion of the net cost of all services provided under Medicare Part D;
- Reductions to reflect any recoveries from other payors outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care. These adjustments shall exclude any adjustments associated with coverage of Medicare Part D services; and
- Adjustments resulting from CMS and the State review of Contractor reimbursement methodologies and levels to address any excessive pricing.

1.7. **Advance Directive –** An individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under State law (whether statutory or as recognized by the courts of the State) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

1.8. **Adverse Benefit Determination --** (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Contractor, the denial of an Enrollee's request to obtain services outside of the Network; or (vii) the denial of an Enrollee's request to dispute a financial liability.

1.9. **Appeal** - In general, an Enrollee's actions, both internal and external to the Contractor requesting review of the Contractor's denial, reduction or termination of benefits or services, from the Contractor. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and

regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by the Contractor of an Adverse Benefit Determination.

1.10. **Behavioral Health —** An all-inclusive term referring to mental health services provided through the mental health plan (MHP) or Contractor and substance use disorder services.

1.11. **Cal MediConnect —** California's State-specific name for the Capitated Financial Alignment Model Demonstration.

1.12. **Cal MediConnect Plan (also, Contractor) —** A health plan or other qualified entity jointly selected by the State and CMS for participation in this Demonstration.

1.13. **Cal MediConnect Ombuds Program-** The independent contractor established to safeguard the rights and dignity of all beneficiaries supported by Cal MediConnect. This office will be responsible for assisting and resolving issues that Enrollees may encounter with Cal MediConnect Plans.

1.14. **California (or State) —** For purposes of this document, California (or State) is generally used to refer to DHCS, though it may encompass collectively CDA, DHCS, DMHC, and DSS.

1.15. **Capitated Financial Alignment Model Demonstration ("the Demonstration") —** A model in which a state, CMS, and a Contractor enter into a three-way Contract, and the Contractor receives a prospective blended capitation payment to provide comprehensive, coordinated care.

1.16. **Capitated Financial Alignment Model Memorandum of Understanding (CFAM-MOU) —** For purposes of this Contract, this is a document between CMS and California regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model (signed March 27, 2013). This MOU document details the principles under which CMS and the State plan to implement and operate the Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute this Contract setting forth the terms and conditions of the Demonstration and initiate the Demonstration.

1.17. **Capitation Rate —** The sum of the monthly capitation payments (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract). Total Capitation Rate Revenue will be calculated as if all Contractors had received the full

quality withhold payment.

1.18. **Care Coordination** –Delineated through requirements, processes and the care model throughout this Contract, Care Coordination is also detailed in WIC Sections 14182.17(d)(4) and 14186(b).

1.19. **Care Coordinator** — A clinician or other trained individual employed or contracted by the PCP or the Contractor who is accountable for providing Care Coordination services, which include assuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the Primary Care Provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one (1) or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.

1.20. **Care Plan Option (CPO) Services** – A CPO Service is optional under the beneficiary's Individualized Care Plan (ICP). A CPO Service is designed to only supplement, not replace, the required Medi-Cal services under the beneficiary's Individualized Care Plan (ICP). CPO Services are offered entirely at the Contractor's discretion.

1.21. **Centers for Medicare & Medicaid Services (CMS)** — The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

1.22. **Chronic Mental Disorder** — To be considered to have a Chronic Mental Disorder, the Enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilias, (m) Gender Identity Disorders, (n) Eating Disorders, (o) Impulse Control Disorders Not Elsewhere Classified (p) Adjustment Disorders, (q) Personality Disorders, or (r) Medication-Induced

Movement Disorders.

1.23. **Community Based Adult Services (CBAS) —** Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.

1.24. **Contract —** The participation agreement that CMS and DHCS have with a Contractor, for the terms and conditions pursuant to which a Contractor may participate in this Demonstration.

1.25. **Contract Management Team (CMT) —** A group of CMS and DHCS representatives responsible for overseeing the contract management functions outlined in Section 3.1.1 of the Contract.

1.26. **Contract Operational Start Date —** The first date on which enrollment into the Contractor's Cal MediConnect coverage is effective.

1.27. **Contractor —** An entity approved by CMS and DHCS that enters into a Contract with CMS and DHCS in accordance with, and to meet, the purposes specified in this Contract.

1.28. **County Organized Health System (COHS) —** A type of Medi-Cal managed care delivery model in which DHCS contracts with a single health plan created by the County Board of Supervisors.

1.29. **County Social Services Agency**- Local county agency that administers the IHSS program.

1.30. **Covered Services —** The set of services to be offered by the Contractor as defined in Appendix A.

1.31. **Department of Aging (CDA) –** In California, CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. CDA administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program. CDA certifies CBAS centers for participation in the Medi-Cal Program and provides administrative oversight for the MSSP waiver.

1.32. **Department of Health Care Services (DHCS) –** The State department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the

State in this document**.**

1.33. **Department of Managed Health Care (DMHC**) – The State department charged with overseeing health care service plans licensed under the Knox-Keene Act.

1.34. **Department of Social Services (CDSS)** – The State department responsible for overseeing and providing social services, including the In Home Support Services (IHSS) program.

1.35. **Developmental Disability –** A disability which originates before the individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

1.36. **Drug Medi-Cal Benefits –** The substance use disorder Medi-Cal benefits that are listed in Title 22, California Code of Regulations, section 51341.1(d) and Welfare and Institutions Code section 14132.03 .

1.37. **Dual-Plan Letter (DPL) -** DPLs convey information or interpretation of changes in policy or procedure at the federal or State levels, and about changes in federal or State law and regulations. DPLs provide instruction to the Contractor on how to implement these changes on an operational basis, and about how federal or State law affect the way in which they operate, or deliver services to Enrollees. The Department shall notify and consult with stakeholders, including the Contractor, prior to the issuance of a DPL in compliance with the provisions of Welfare and Institutions Code section 14186.4(c).

1.38. **Emergency Medical Condition —** A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.39. **Emergency Services** – Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical

Condition.

1.40. **Encounter Data -** The record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. This record must incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, Privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.

1.41. **Enrollee —** Any Medicare-Medicaid eligible individual who is enrolled with a Contractor.

1.42. **Enrollee Communications —** Materials designed to communicate Covered Services, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.

1.43. **Enrollment Broker —** Entity contracted by DHCS through the Health Care Options Program to provide information and enrollment assistance to Medicare-Medi-Cal beneficiaries.

1.44. **Exempt Grievance –** Grievances received by telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt.

1.45. **External Quality Review Organization --** An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by the Contractor to their Enrollees.

1.46. **Federally-Qualified Health Center (FQHC) —** An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(a)(2)(C).

1.47. **First Tier, Downstream and Related Entity —** An individual or entity that enters into a written arrangement that is acceptable to CMS and DHCS with the Contractor, to provide administrative or health care services to the Contractor under this Contract.

1.48. **Geographic Managed Care (GMC) County —** A county in which DHCS contracts with two or more Knox Keene licensed health plans for Medi-Cal managed care.

1.49. **Grievance:**" Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an

Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. A Grievance is filed and decided at the Contractor level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee's rights as provided for in Appendix B of this Contract). Also called a "Complaint."

1.50. **Health Care Options Program (HCO)** -- A program within the California Department of Health Care Services which operates as an Enrollment Broker providing enrollment assistance to eligible MMP beneficiaries.

1.51. **Health Outcomes Survey (HOS) —** Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.52. **Health Plan Management System (HPMS) —** A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

1.53. **Health Risk Assessment —** An assessment tool which identifies primary, acute, long-term services and supports, and Behavioral Health and functional needs.

1.54. **Healthcare Effectiveness Data and Information Set** (**HEDIS) —** Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

1.55. **High Risk Enrollee —** For risk stratification purposes, an Enrollee who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact by the Contractor within forty-five (45) calendar days after coverage date. The higher risk Enrollees who should be identified from the fee for service utilization data,

include but are not limited to Enrollees who:

- Have been on oxygen within the past ninety (90) days,
- Have been hospitalized within the last ninety (90) days, or have had three (3) or more voluntary and/or involuntary hospitalizations within the past year related to Behavioral Health illnesses,
- Have had three (3) or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases),
- Have In Home Supportive Services (IHSS) greater than or equal to one hundred ninety five (195) hours/month,
- Are enrolled in the Multipurpose Senior Service Program (MSSP),
- Are receiving Community Based Adult Services (CBAS),
- Have ESRD, AIDS, and/or a recent organ transplant,
- Have been currently being treated for cancer,
- Have been prescribed anti-psychotic medication within the past ninety (90) days,
- Have been prescribed fifteen (15) or more medications in the past ninety (90) days, or
- Have other conditions as determined by the Contractor, based on local resources.

1.56. **Indian Enrollee —** An Enrollee who is an Indian (as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12.) This includes an Enrollee is a member of a Federally recognized tribe; resides in an urban center and meets one or more of four criteria including: is member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; is an Eskimo or Aleut or other Alaska Native; is considered by the Secretary of the Interior to be an Indian for any purpose; or is determined to be an Indian under regulations issued by the Secretary; is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native Enrollee.

1.57. **Indian Health Care Provider –** A health care program operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the

Indian Health Care Improvement Act (25 U.S.C. § 1603).

1.58. **Individualized Care Plan (ICP or Care Plan)** — The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

1.59. **Interdisciplinary Care Team (ICT)** — A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Enrollee, that works with the Enrollee to develop, implement, and maintain the ICP.

1.60. **In-Home Supportive Services (IHSS)** — Pursuant to Article 7 of California Welfare and Institutions Code (Welf. & Inst. Code) (commencing with section 12300 of Chapter 3, and sections 14132.95, 14132.952, and 14132.956), IHSS is a program that provides in-home care for people who cannot safely remain in their own homes without assistance.

1.61. **Long Term Services and Supports (LTSS)** — A wide variety of services and supports that help eligible beneficiaries meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following:

- In-Home Supportive Services (IHSS);
- Community-Based Adult Services (CBAS);
- Multipurpose Senior Services Program (MSSP) services; and
- Skilled Nursing Facility services and subacute care services.

1.62. **Low Risk Enrollee** —Enrollee who does not meet the minimum requirements of a High Risk Enrollee.

1.63. **Marketing, Outreach, and Enrollee Communications** — Any informational materials targeted to Enrollees that are consistent with the definitions of communication materialsand marketing materials at 42 C.F.R. § 422.2260.

1.64. **Medicaid** — The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof. California's State-specific name for this program is Medi-Cal.

1.65. **Medi-Cal Dental –** Adult dental benefits provided through Medi-Cal

(California's Medicaid program).

1.66. **Medi-Cal Managed Care Behavioral Health Services -** Behavioral Health services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor.

1.67. **Medi-Cal Managed Care Plan** – A health plan directly contracted with the California Department of Health Care Services to provide Medi-Cal services to eligible beneficiaries.

1.68. **Medi-Cal Appeal** - A request for a fair hearing in accordance with California Code of Regulations Title 22, section 51014.1 and Welfare and Institutions Code section 10950.

1.69. **Medically Necessary Services** — Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under the Welfare and Institutions Code section 14059.5.

1.70. **Medi-Cal Specialty Mental Health Services** — The Medi-Cal services specified in California Code of Regulations, Title 9 section 1810.247. Specialty mental health services do not include the Medi-Cal Managed Care Behavioral Health Services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor. Specialty mental health services are provided through a MHP, in accordance with California Code of Regulations, Title 9, Chapter 11 of Division 1 and include:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;
B. Psychiatric inpatient hospital services;
C. Targeted Case Management;
D. Psychiatrist services; and
E. Psychologist services.

1.71. **Medicare —** Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.72. **Medicare Advantage —** The Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at 42 C.F.R. Part 422.

1.73. **Medicare Appeal —** An Enrollee's request for formal review of an Adverse Benefit Determination of the Contractor in regards to a Medicare service in accordance with Section 2.15.

1.74. **Medicare-Medicaid Coordination Office —** Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

1.75. **Medicare-Medicaid Enrollee (or Enrollee) —** For the purposes of this Demonstration, an individual who is entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, and enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

1.76. **Medicare-Medicaid Plan (MMP)** -- A health plan contracted with DHCS and CMS to comprehensively manage the full continuum of Medicare and Medi-Cal benefits for Medicare-Medicaid Enrollees including Long Term Supports and Services as needed and desired by the Enrollee.

1.77. **Mental Health Plan (MHP):** Pursuant to California Code of Regulations, Title 9 section 1810.226, a MHP is an entity that enters into a contract with DHCS to provide directly, or arrange and pay, for Medi-Cal Specialty Mental Health Services. A MHP may be a county, counties acting jointly or another

governmental or non-governmental entity.

1.78. **Minimum Data Set (MDS) —** A clinical screening system, mandated by federal law for use in nursing facilities, that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 2.0 for nursing facility residents.

1.79. **Multi-Purpose Senior Services Program (MSSP**) **—** A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

1.80. **Network Provider —** An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any First Tier, Downstream, or Related Entity, for the delivery of services covered under the Contract. A Network Provider must meet the requirements in Section 2.9.9.1.

1.81. **Notice of Action (NOA) –** A written notice of any action within the timeframes for each type of action as provided by 42 C.F.R. §§ 438.404 and 422.568.

1.82. **Passive Enrollment —** An enrollment process through which an eligible individual is enrolled by DHCS into a Contractor's plan following a minimum sixty (60) day advance notification that includes the opportunity for the Enrollee to choose another plan or opt out prior to the effective date.

1.83. **Post-Stabilization Care Services —** Services related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or are provided, to improve or resolve the condition.

1.84. **Primary Care Provider (PCP) --** A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

1.85. **Privacy —** Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant California privacy laws.

1.86. **Program of All-Inclusive Care for the Elderly (PACE) —** As defined in 42 C.F.R. § 460.6, and authorized under California law at Welfare and

Institutions Code section 14591 et seq., PACE is a capitated program for individuals over the age of 55 certified by DHCS for nursing home level of care. PACE organizations cover all Medicare and Medicaid benefits, including medical services and long-term services and support, organizes a comprehensive service delivery system governed by federal regulations, and integrate Medicare and Medicaid financing. PACE is a three-way partnership between the federal Government, California, and the PACE Organizations.

1.87. **Provider Network —** A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, Care Coordinators, specialty providers, Behavioral Health providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor. (See Appendix C of the Contract).

1.88. **Readiness Review —**Prior to being eligible to accept Demonstration enrollments, each prospective Contractor selected to participate in the Demonstration must undergo a Readiness Review. The Readiness Review evaluates each prospective Contractor's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Covered Services that are Medically Necessary with Enrollee protections. Only Contractors passing the Readiness Review will participate in the Demonstration. At a minimum, each Readiness Review includes a desk review and a site visit to the prospective Contractor's headquarters.

1.89. **Recovery Model —** Framework for Behavioral Health that uses "recovery-oriented" services in recognition that systems of care should ensure culturally competent care for persons with severe mental illness and substance use disorders in the most appropriate, least restrictive level of care necessary to achieve meaningful outcomes such as health, home, purpose and community, consistent with the system of care as set forth in California Welfare and Institutions Code sections 5802 and 5806. Core practices within recovery-oriented systems include peer support, individual choice and person-driven approaches. The Recovery Model recognizes that Behavioral Health issues involve an individualized complex interaction between social, environmental and physiological components, and the need to incorporate all of these factors

within the care system in order to achieve health and wellness.

1.90. **Request for Solutions** — Document released in December 2011 by DHCS to assess if contractors have the requisite qualifications and resources suited to provide seamless access to the full continuum of medical care and social supports and services that Enrollees need to maintain good health and a high quality of life in the setting of their choice.

1.91. **Rural Health Clinic (RHC) –** An entity that meets all of the requirements for designation as a RHC under § 1861(aa)(1) of the Social Security Act and is approved for participation in the Medi-Cal program.

1.92. **Service Area** — The county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by CMS and DHCS to operate under the terms of this Contract. See Appendix I for the Service Area for this contract.

1.93. **Skilled Nursing Facility (SNF)** — As defined in California Code of Regulations, Title 22 section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing facility".

1.94. **State Fair Hearing** — A "State Fair Hearing" is a quasi-judicial proceeding conducted by a judge, during which each hearing party may present arguments and evidence, including witness(es), and cross examine witness(es) against them, with respect to a decision regarding the availability or delivery of services or benefits, made by an agency. An "agency" is a government unit or managed care health plan involved in a hearing as a hearing party. Such agencies include all 58 California counties, the Los Angeles Department of Children and Family Services, the California Department of Aging, the CDSS Office of Services to the Blind, all 27 Medi-Cal Field Offices, and several CDHS units, including: Beneficiary Utilization Review Unit, Benefits Branch-Vision, In-Home Operations, Managed Care

Operations Branch, Recovery Section, and Office of Medi-Cal Dental Services.

1.95. **Streamlined Enrollment:** A process to permit Contractors operating in non-COHS counties to submit opt-in enrollments to DHCS on behalf of their members enrolled in the matching plan's Medi-Cal line of business.

1.96. **Threshold Languages —** As specified in annual guidance to Contractors on specific translation requirements for their service areas.

1.97. **Total Adjusted Expenditures –** The sum of the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures.

1.98. **Total Capitation Rate Revenue –** The sum of the monthly capitation payments for the Demonstration Year (reflecting coverage of Medicare Parts A/B services, Medicare Part D services and Medi-Cal services, pursuant to Appendix A of this contract) including: 1) the application of risk adjustment methodologies, as described in Section 4.2; and 2) any payment adjustments as a result of the reconciliation described in Sections 4.13 and 4.14. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

1.99. **Two- Plan County —** A type of Medi-Cal managed care delivery model in which DHCS contracts two plans, offering beneficiaries a choice of health plan a with a "Local Initiative" (LI) and a "commercial plan" (CP). An LI is a non-profit, locally government health plan serving Medi-Cal beneficiaries.

1.100. **Urgent Care — S**ervices required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

2. Contractor Responsibilities

Through the Capitated Financial Alignment Model Demonstration (the "Demonstration"), CMS and DHCS will work in partnership to offer Medicare-Medicaid Enrollees the option of enrolling in a Contractor's plan, which consists of a comprehensive network of health and social service providers. The Contractor will deliver and coordinate all components of Medicare and Medi-Cal Covered Services for Enrollees.

2.1. Compliance: The Contractor must, to the satisfaction of CMS and DHCS:

2.1.1. Comply with all provisions set forth in this Contract.

2.1.2. Comply with all applicable provisions of federal and State laws, the CFAM-MOU, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422, Part 423, and Part 438 except to the extent that variances from these requirements are provided in the CFAM-MOU.

2.1.3. Maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 as amended and have no adverse actions with regard to enforcement or quality management. County-Organized Health System (COHS) plans are exempt from Knox-Keene licensure for their Medi-Cal business pursuant to WIC section 14087.95. Despite this exemption from licensure, this Contract obligates all Contractors, including COHS plans, to comply with all provisions of this Contract, including the contractual provisions relating to the Knox-Keene Act, unless otherwise expressly excluded.

2.1.4. The Contractor agrees that it will develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455.

2.1.4.1. The Contractor must report all employees, providers, and Enrollees suspected of Fraud, waste, and/or Abuse that warrant investigation to DHCS – Office of Inspector General, the Medicaid Fraud Control Unit and CMS.

2.1.5. Comply with all current and applicable DPLs issued by DHCS. All current DPLs can be viewed at: http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanL

etters.aspx

2.1.5.1. All DPLs will be reviewed by CMS prior to issuance.

2.1.6. In the event an APL applies to an MMP, DHCS and CMS will jointly issue a memo to the plans via HPMS for the interim period between an APL issuance and a DPL issuance.

2.1.7. Maintain its contract with DHCS for the provision of Covered Services under the Medi-Cal program.

2.1.8. For Contractors that make or receive payments under the contract of at least $5,000,000, the Contractor must adopt and implement written policies for all employees of the Contractor, and of any contractor or agent of the Contractor, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS, or its designee, with participation by DHCS, will conduct a Readiness Review of each Contractor, which must be completed successfully prior to the Contract Operational Start Date.

2.2.1.2. CMS and DHCS Readiness Review Responsibilities

2.2.1.2.1. CMS and DHCS, or its designees, will conduct a Readiness Review of each Contactor that will include, at a minimum, one on-site review. This review shall be conducted prior to enrollment of beneficiaries into the Contractor's Plan. CMS and DHCS, or its designees, will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

2.2.1.2.2. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.2.1. Network Provider composition and access, in accordance with Section 2.10;

2.2.1.2.2.2. Staffing, including Key Personnel and functions directly impacting on Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with Section 2.11;

2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix C;

2.2.1.2.2.4. Care Coordination capabilities, in accordance with Section 2.5.2;

2.2.1.2.2.5. Provider contracts templates, including any Provider Performance Incentives, in accordance with Sections 2.9 and 5.1.7;

2.2.1.2.2.6. Enrollee services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.12;

2.2.1.2.2.7. Comprehensiveness of quality management/quality improvement and utilization management strategies, in accordance with Section 2.11.6 and 2.16;

2.2.1.2.2.8. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.14 and 2.15;

2.2.1.2.2.9. Fraud and abuse and program integrity, in accordance with Section 2.1.2;

2.2.1.2.2.10. Financial solvency, in accordance with Section 2.18;

2.2.1.2.2.11. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.19, including IT testing and security assurances.

2.2.1.2.3. For Contractors that are COHS plans, the scope of the Readiness Review will extend to the enrollment functions that the Contractor will be conducting as described in Section 2.3.1.

2.2.1.2.4. No individual shall be enrolled into the Contractor's Cal MediConnect Plan unless and until CMS and the DHCS determine that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.5. CMS and DHCS or its designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the start of marketing.

2.2.1.2.6. CMS or DHCS may, in its discretion, postpone the date the Contractor may start marketing or the Contract Operational Start Date for any Contractor that fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy CMS or DHCS that it is ready and able to perform its obligations under the Contract prior to the start of marketing or the Contract Operational Start Date, and CMS or DHCS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or DHCS may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3. Contractor Readiness Review Responsibilities

2.2.1.3.1. The Contractor shall demonstrate to CMS and DHCS satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing of its Demonstration product;

2.2.1.3.2. Provide CMS and DHCS or its designee with the corrected materials requested by the Readiness Review.

2.2.2. Contract Management

2.2.2.1. The Contractor must employ a qualified individual to serve as the compliance officer of its Capitated Financial Alignment Model. The compliance officer must be primarily dedicated to the Contractor's program, hold a senior management position in the Contractor's organization, and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program. The compliance officer must act as liaison between the Contractor, CMS, and DHCS, and has responsibilities pursuant to this Contract, DPLs and other relevant guidance and authorities that include but, are not limited to, the following:

2.2.2.1.1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the approved Request for Solutions (RFS);

2.2.2.1.3. Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities.

2.2.2.1.4. Receive and respond to all inquiries and requests made by CMS and DHCS in timeframes and formats specified by CMS and DHCS;

2.2.2.1.5. Meet with representatives of CMS or DHCS, or both, on a periodic or as-needed basis and resolve issues that arise within specified timeframes;

2.2.2.1.6. Ensure the availability to CMS and DHCS upon their request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee

services, utilization management, Provider Network management, and benefit coordination;

2.2.2.1.7. Coordinate requests and activities among the Contractor, all First Tier, Downstream and Related Entities CMS, and DHCS;

2.2.2.1.8. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, CMS, or DHCS; and

2.2.2.1.9. Meet with CMS and DHCS at the time and place requested by CMS and the State, determine that the Contractor is not in compliance with the requirements of the Contract.

2.2.3. Organizational Structure

2.2.3.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with:

2.2.3.1.1. County Organized Health System, Geographic Managed Care, and Two- Plan County: Title 28 CCR Sections 1300.67.3, 1300.75.1, 1300. 76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code, Section 1375.1.

2.2.4. Delegation Oversight

2.2.4.1. Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

2.2.4.2. Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

2.2.4.3. Contractor's Quality Improvement (QI) department shall maintain documentation of oversight activities.

2.2.4.4. Contractor's delegation oversight and monitoring activities shall emphasize results. To that end, Contractor shall identify areas requiring improvement and shall monitor the performance of the First Tier, Downstream, and Related Entities to ensure that such improvement occurs.

2.2.4.5. Contractor delegates activities to its First Tier, Downstream, and Related Entities in accordance with terms and conditions, contracts, applicable regulations, and this contract.

2.2.4.6. Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

2.2.4.6.1. Desktop and annual on-site revises;

2.2.4.6.2. Monitoring; and

2.2.4.6.3. Continuous improvement activities.

2.3. Enrollment Activities

2.3.1. General Enrollment

2.3.1.1. Contractor shall accept all eligible beneficiaries as defined in Appendix J – Eligible Populations.

2.3.1.2. Eligible beneficiaries residing within the Contractor Service Area may be enrolled at any time up to six (6) months prior to the end of the Demonstration. Eligible beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, need for health care services or disability.

2.3.1.3. Enrollee coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the eligible beneficiary's name is added to the approved list of Enrollees furnished by CMS and the DHCS Enrollment Broker. The term of enrollment shall continue unless this Contract expires, is terminated, or the Enrollee is disenrolled under the conditions described in Section 2.3.2, Disenrollment.

2.3.1.4. Enrollment will proceed unless restricted by CMS or the Sstate. Such restrictions will be defined in writing by CMS or the Sstate and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) days calendar prior to the date of the release.

2.3.1.5. Intelligent Assignment. Enrollment activities specific to Two-Plan Counties and GMC Counties (Los Angeles, San Diego, San Bernardino, Santa Clara, Riverside):

2.3.1.5.1. On a quarterly basis, Contractor shall provide DHCS with a complete list of Network Providers and National Provider Identifier (NPI) numbers to assist in the assignment of eligible beneficiaries as part of the Passive Enrollment process. The Network Provider list will include all Network Providers for the Provider Network, where applicable.

2.3.1.5.2. Updates to the Network Provider list shall be sent to DHCS on a quarterly basis for the purposes of intelligent assignment, or as changes to the Provider Network are applied.

2.3.1.5.3. As part of the Enrollment process, DHCS will exclude individuals identified as at-risk or potentially at-risk for abuse or overuse of specified prescription drugs per 42 C.F.R. §§ 423.100 and 423.153(f).

2.3.1.5.4. As part of the Passive Enrollment process, DHCS will initially assign an Enrollee to a Cal MediConnect Plan based on a hierarchical logic in accordance with Section 2.3.1.5.1. Subject to 42 C.F.R. §§ 423.100 and 423.153(f), Enrollees shall have the ability to change Cal MediConnect Plans at any time.

2.3.1.5.4.1. DHCS shall utilize the following hierarchical logic to determine Primary Contractor Plan assignment:

2.3.1.5.4.1.1. If a beneficiary is in a Medi-Cal Managed Care Plan that is participating in the Cal MediConnect

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Program and is not enrolled in a Medicare Advantage product, DHCS will assign the beneficiary to the matching Cal MediConnect plan.

2.3.1.5.4.1.2. If the beneficiary is in a Medicare Advantage Dual Special Needs Plan owned by the parent organization of an MMP, DHCS will assign the beneficiary to the matching MMP.

2.3.1.5.4.1.3. If a beneficiary is in fee-for-service Medi-Cal and Medicare, DHCS will match the beneficiary's highest utilized and paid prescribing and/or rendering provider data [based on the most recent and available twelve (12) months of Medicare and Medi-Cal claim data] to the list of Network Providers supplied by the Contractor, in accordance with Section 2.3.1.5.1.

2.3.1.5.4.1.4. If only one (1) Cal MediConnect Plan is identified with the beneficiary's provider(s) in its network, DHCS will assign the beneficiary to that Cal MediConnect Plan.

2.3.1.5.4.1.5. If two (2) or more Cal MediConnect Plans are identified or if there is insufficient claim data to match to a Cal MediConnect Plan, the system will select a Cal MediConnect Plan based on an equal distribution ratio. For example, if there are two (2) Cal MediConnect Plans in the county, DHCS will assign based on a 50/50 split. In San Diego, the system will divide beneficiary assignments equally across the four (4) Cal MediConnect Plans.

2.3.1.5.4.1.6. This distribution is dependent on Contractor capacity and subject to be altered per the direction of the Contract Management Team (CMT).

2.3.1.5.5. DHCS will notify CMS and the Contractor of the beneficiary assignments via the enrollment transactions sent to CMS and the 834 Enrollment file.

2.3.1.5.6. DHCS will inform the Contractor of the provider NPIs used in the plan selection process.

2.3.1.5.7. CMS will notify the Contractor of the beneficiary assignments via the Daily Transaction Response Reply (DTRR) file distributed through the CMS Enrollment Broker.

2.3.1.5.8. Contractor is responsible for outreach to the Network Provider for enrollment related activities and for providing data to DHCS.

2.3.1.5.9. Contractor shall maintain systems to accept enrollment transactions from CMS' and the State's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, posted at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf

2.3.1.6. Enrollment activities specific to County Organized Health Systems.

2.3.1.6.1. Contractor shall maintain systems to identify eligible beneficiaries as defined in Appendix J, and transmit enrollment transactions to CMS and the State's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance Document.

2.3.1.7. Subject to CMT approval and Section 2.17.1.1.2, the Contractor may participate in Streamlined Enrollment.

2.3.1.7.1. Eligible Enrollees must be enrolled in the Contractor's Medi-Cal plan product.

2.3.1.8. CMS and DHCS may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the Contractor in making any such adjustments.

2.3.1.9. The Contractor may, via the CMT, request a capacity limit pursuant to 42 C.F.R. § 422.60. For purposes of this Demonstration, CMS and DHCS will consider financial stability and network adequacy in the determination of a capacity limit.

2.3.2. Disenrollments

2.3.2.1. The Contractor shall have a mechanism for receiving timely information about all disenrollments from the Contractor's plan, including the effective date of disenrollment, from CMS and DHCS systems.

2.3.2.2. Contractor in Two-Plan and GMC Counties shall have processes and procedures in place to refer Enrollees that request disenrollment from the Plan to the DHCS Enrollment Broker.

2.3.2.3. Enrollees with a share of cost that do not meet the share of cost on the first of the month will be deemed eligible and remain enrolled for up to two (2) months at the Contractor's responsibility before being disenrolled per California's State-specific guidance to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (Section 2.3.1.5.9.). Please see Appendix J for eligibility requirements for beneficiaries with a share of cost.

2.3.2.4. Subject to 42 C.F.R. §§ 423.38 and 423.100, Enrollees can elect to disenroll from the Cal MediConnect Plan or the Demonstration at any time and enroll in another Cal MediConnect Plan in a Two-Plan County or GMC county, a Medicare Advantage plan, PACE (as otherwise permissible); or elect to receive services through Medicare fee-for-service and a prescription drug plan and to receive Medicaid services in accordance with DHCS's Medi-Cal program and any waiver programs. (see Appendix L) Disenrollments received by DHCS or its contractor, or by CMS or its

contractor, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.2.4.1. The Contractor shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

2.3.2.4.2. DHCS and CMS shall terminate an Enrollee's coverage upon any of the occurrences specified in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, including but not limited to the following:

2.3.2.4.2.1. The Enrollee's death. This disenrollment is effective the first day of the calendar month following the month of death. Termination may be retroactive to the month in which the Enrollee dies.

2.3.2.4.2.2. When an Enrollee elects to change Demonstration Plans. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

2.3.2.4.2.3. When an Enrollee requests and is enrolled in a new Medicare Advantage plan through 1-800-Medicare. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

2.3.2.4.2.4. When an Enrollee elects to receive his or her Medicare services through Medicare fee-for-service and a separate Medicare prescription drug plan.

2.3.2.4.2.5. The termination or expiration of this Contract terminates coverage for all Enrollees with the Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the parties.

2.3.2.4.3. The Contractor may not request the disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The Contractor, however, may submit a written request, accompanied by supporting documentation to the CMT to disenroll an Enrollee, for cause, for the following reasons:

2.3.2.4.3.1. Enrollee remains out of the Service Area or cannot be located for more than six (6) consecutive months; or

2.3.2.4.4. The Contractor may not threaten, intimidate, pressure, or otherwise interfere with the Enrollee's right to disenroll.

2.3.2.5. Discretionary Involuntary Disenrollment: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to Cal MediConnect Plans on discretionary involuntary disenrollment. This Contract and other guidance provide procedural and substantive requirements the Contractor, DHCS, and CMS must follow prior to involuntarily disenrolling an Enrollee. If all of the procedural requirements are met, DHCS and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements.

2.3.2.5.1. Bases for Discretionary Involuntary Disenrollment:

2.3.2.5.1.1. Disruptive conduct: When the Enrollee engages in conduct or behavior that substantially impairs the Contractor's ability to furnish Covered Items and Services to either this Enrollee or other Enrollees and provided the Contractor made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.2.5.2. Procedural requirements:

2.3.2.5.2.1. The Contractor's request must be in writing and include all of the supporting documentation outlined under the evidentiary standards in Section 2.3.2.5.3.

2.3.2.5.2.2. The process requires three (3) written notices. The Contractor must include in the request, submitted to DHCS and CMS, evidence that the advance notice and notice of intent have already been sent to the Enrollee. The notices are:

2.3.2.5.2.2.1. Advance notice to inform the Enrollee that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include a clear and thorough explanation of the disruptive conduct and its impact on the Contractor's ability to provide services, examples of the types of reasonable accommodations the Contractor has already offered, the Grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the Contractor must begin the process again. This includes sending another advance notice.

2.3.2.5.2.2.2. Notice of intent to request the State and CMS' permission to disenroll the Enrollee; and

2.3.2.5.2.2.3. Planned action notice advising that CMS and the State have approved the Contractor's request. This planned action notice is not a procedural prerequisite for

approval and should not be sent under any circumstances prior to the receipt of express written approval and a disenrollment transaction from CMS and DHCS.

2.3.2.5.2.3. The Contractor must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;

2.3.2.5.2.4. The submission must include statements from providers describing their experiences with the Enrollee (or refusal in writing, to provide such statements); and

2.3.2.5.2.5. Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.

2.3.2.5.2.6. If the Contractor is requesting the ability to decline future Enrollments for this individual, the Contractor must include this request explicitly in the submission.

2.3.2.5.2.7. Prior to approval, the complete request must be reviewed by DHCS and CMS including representatives from the Center for Medicare and must include staff with appropriate clinical or medical expertise.

2.3.2.5.3. Evidentiary standards: At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both DHCS and CMS staff with appropriate clinical or medical expertise:

2.3.2.5.3.1. The Enrollee is presently engaging in a pattern of disruptive conduct that is seriously impairing the Contractor's ability to furnish Covered Items and Services to the Enrollee and/or other Enrollees.

2.3.2.5.3.2. The Contractor took reasonable efforts to address the disruptive conduct including at a minimum:

2.3.2.5.3.2.1. A documented effort to understand and address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act including those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. DHCS and CMS will determine whether the reasonable accommodations offered are sufficient.

2.3.2.5.3.2.2. A documented provision of information to the individual of his or her right to use the Grievance procedures.

2.3.2.5.3.2.3. The Contractor provided the Enrollee with a reasonable opportunity to cure his/her disruptive conduct.

2.3.2.5.3.3. The Contractor must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of medical services.

2.3.2.5.3.4. The Contractor may also provide evidence of other extenuating circumstances that demonstrate the Enrollee's disruptive conduct;

2.3.2.5.4. Limitations: The Contractor shall not seek to terminate enrollment because of any of the following:

2.3.2.5.4.1. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless treating providers explicitly document their belief that there are no reasonable accommodations the Contractor could provide that would address the disruptive conduct.

2.3.2.5.4.2. The Enrollee exercises the option to make treatment decisions with which the Contractor or any health care professionals associated with the Contractor disagree, including the option of declining treatment and/or diagnostic testing.

2.3.2.5.4.3. An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Items and Services.

2.3.2.5.4.4. The Enrollee's mental capacity is, has, or may become diminished.

2.3.2.5.5. Fraud or abuse: When the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.3.2.5.5.1. The Contractor may submit a request that an Enrollee be involuntarily disenrolled if an Enrollee knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the Contractor's plan; or if the Enrollee intentionally permits others to use his or her enrollment card to obtain services from the Contractor.

2.3.2.5.5.2. Prior to submission, the Contractor must have and provide to CMS/DHCS credible evidence substantiating the allegation that the Enrollee knowingly provided fraudulent information or intentionally permitted others to use his or her card.

2.3.2.5.5.3. The Contractor must immediately notify the CMT so that the Enrollment Broker and the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

2.3.2.5.6. The Contractor must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the plan's decision and information on the Enrollee's access to Grievance procedures and a fair hearing.

2.4. Covered Services

2.4.1. The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the Contractor. Covered Services include the Behavioral Health services that become Medi-Cal managed care benefits, pursuant to Welfare and Institutions Code section 14132.03.

2.4.2. The Contractor must provide the full range of Covered Services. If either Medicare or Medi-Cal provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program.

2.4.3. Care Plan Option (CPO) Services may be provided at the sole discretion of the Contractor and in accordance with the ICP.

2.4.3.1. The Grievance and Appeals process for CPO Services shall be the same process as used for others benefits authorized by the Contractor, as described in Sections 2.14 and 2.15, and shall comply with Welfare & Institutions Code section 14450 and Health & Safety Code sections 1368 and 1368.1.

2.4.3.2. CPO Services may include, but are not limited to:

2.4.3.2.1. Respite care: in home or out-of-home, which shall not supplant authorized IHSS hours;

2.4.3.2.2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; Contractor will

notify counties if additional personal care services are provided.

2.4.3.2.3. Nutritional assessment, supplements, and home delivered meals;

2.4.3.2.4. Home maintenance and minor home or environmental adaptation; and

2.4.3.2.5. Supplemental protective supervision.

2.4.3.3. Other services and requirements in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

2.4.4. The Contractor may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

2.4.4.1. Furnished by the Contractor by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2);

2.4.4.2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person;

2.4.4.3. Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

2.4.4.4. Furnished by an individual or entity that is included on the preclusion list, as defined in 42 C.F.R. § 422.222.

2.4.5. The Contractor may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

2.5. Care Delivery Model

2.5.1. Contractor shall abide by the care delivery model described within this Contract and is not required to submit a model of care to CMS or DHCS unless otherwise requested.

2.5.2. Care Coordination. The Contractor shall offer Care Coordination and case management services to all Enrollees, as described in Welfare and Institutions Code sections 14182.17(d)(4) and 14186(b).

2.5.2.1. Contractor will coordinate Enrollee care across the full continuum of service providers, including medical, Behavioral Health, and LTSS.

2.5.2.2. Contractor will focus on providing services in the least restrictive setting.

2.5.2.3. Care Coordination will be led by the Care Coordinator with participation by members of the ICT.

2.5.2.4. Contractor shall ensure effective linkages of clinical and management systems among Network Providers. Such linkages shall be established in plan policies and procedures.

2.5.2.4.1. Such linkages shall include communication protocols among First Tier, Downstream, and Related Entities.

2.5.2.5. Contractor's policies and procedures shall clarify all communications and reporting protocols related to coordination of services including but not limited to how Contractor shall oversee all such coordination activities.

2.5.2.6. Contractor will ensure that Care Coordination services:

2.5.2.6.1. Reflect a person-centered, outcome-based approach, consistent with the, CFAM-MOU, and DHCS' RFS;

2.5.2.6.2. Follow Enrollee's direction about the level of involvement of his or her caregivers or medical providers;

2.5.2.6.3. Span medical and LTSS systems, including coordination with IHSS, with a focus on transitions;

2.5.2.6.4. Reflect coordination with county agencies and direct contractors, if applicable, for Behavioral Health services;

2.5.2.6.5. Reflect coordination with county agencies, if applicable, for IHSS services;

2.5.2.6.6. Reflect coordination with Medi-Cal Dental and any MMP supplemental dental benefits, as applicable, for dental services;

2.5.2.6.7. Include development of Individual Care Plans (ICP) with Enrollees, as described in Section 2.8.3;

2.5.2.6.8. Are performed by nurses, social workers, Primary Care Providers, if appropriate, other medical, Behavioral Health, or LTSS professionals, and health plan Care Coordinators, as applicable; and

2.5.2.6.9. Reflect access to appropriate community resources, as defined in Welfare and Institution Code sections 14132.275(f)(7) and 14182.17(d) (4)(G) and (6)(B) and monitoring of skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.

2.5.2.7. Contractor will have a process for assigning a Care Coordinator to each Enrollee. Assignment will be made to a Care Coordinator with the appropriate experience and qualifications based on an Enrollee's assigned risk level and individual needs.

2.5.2.7.1. Contractor shall ensure an adequate ratio of Care Coordinators to Enrollees to provide Care Coordination as required through this Contract. The CMT shall monitor the ratio of Care Coordinators to Enrollees on a regular basis.

2.5.2.8. Interdisciplinary Care Team (ICT). The Contractor shall offer an ICT for each Enrollee, which will be developed around the Enrollee and ensure the integration of the Enrollee's medical and LTSS and the coordination of Behavioral Health

Services delivered by a county Behavioral Health agency and IHSS services, when applicable. ICTs must be comprised of professionals appropriate for the needs, preferences, and abilities of the Enrollee.

2.5.2.8.1. Every Enrollee will have access to an ICT.

2.5.2.8.2. Enrollees may request the exclusion of any ICT member.

2.5.2.8.3. Contractor must include information about the ICT and ICP in their new member welcome packets.

2.5.2.8.4. ICT Functions. ICT will facilitate care management, including assessment, care planning, and authorization of services, transitional care issues and work closely with providers listed in Section 2.5.2.8.6.1to stabilize medical conditions, increase compliance with Care Plans, maintain functional status, and meet individual Enrollees Care Plan goals. ICT functions will include, at a minimum:

2.5.2.8.4.1. Develop and implement an ICP with Enrollee and/or caregiver participation as further described in Sections 2.5.2.11.7 and 2.8.3;

2.5.2.8.4.2. Conduct ICT meetings periodically, including at the Enrollee's discretion;

2.5.2.8.4.3. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site;

2.5.2.8.4.4. Maintain a call line or other mechanism for Enrollee inquiries and input , and a process for referring to other agencies, such as LTSS, IHSS, or Behavioral Health agencies, as appropriate;

2.5.2.8.4.5. Conduct conference calls among the Contractor, providers, and Enrollees;

2.5.2.8.4.6. Maintain a mechanism for monitoring Enrollee complaints and Grievances ; and

2.5.2.8.4.7. Use secure email, fax, web portals or written correspondence to communicate. The ICT must take the Enrollee's individual needs (e.g., communication, cognitive, or other barriers) into account in communicating with the Enrollee.

2.5.2.8.5. Composition of ICT. ICT must be person-centered: built on the Enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

2.5.2.8.5.1. The ICT will be led by professionally knowledgeable personnel to address the Enrollee's medical, behavioral and LTSS care. If the ICT is led by a PCP, the PCP must be credentialed.ICT will include the Enrollee and/or authorized representative, family and/or caregiver if approved by the Enrollee, PCP (this may be a specialist, if a specialist is serving as the PCP), Care Coordinator, and may include the following persons, as needed and if applicable:

2.5.2.8.5.1.1. Hospital discharge planner;

2.5.2.8.5.1.2. Nursing facility representative;

2.5.2.8.5.1.3. Social Worker, including the IHSS social worker if IHSS services are provided;

2.5.2.8.5.1.4. Specialized providers, such as pharmacists and physical therapists;

2.5.2.8.5.1.5. If receiving IHSS, the IHSS provider, if authorized by Enrollee;

2.5.2.8.5.1.6. If enrolled in CBAS, the CBAS provider, if authorized by Enrollee;

2.5.2.8.5.1.7. MSSP care manager;

2.5.2.8.5.1.8. Behavioral Health specialist, which may include, but is not limited to, a specialty mental health provider or a substance use disorder counselor; and

2.5.2.8.5.1.9. Other professionals, as appropriate, and as delineated in applicable and current DPLs

2.5.2.8.6. Communication with ICT. Contractor will support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and Enrollees. Contractor will have a documented process for coordinating the exchange of information amongst all ICT members, including when a change in ICT membership occurs.

2.5.2.8.7. Contractor will have procedures for notifying the ICT of emergency department use, hospital admission (psychiatric or acute) or SNF and coordinating a discharge plan.

2.5.2.8.8. Competencies of ICT. Contractor will provide training for ICT members, and potential ICT members, initially and on an annual basis. Required training topics include:

2.5.2.8.8.1. Person-centered planning processes;

2.5.2.8.8.2. Cultural competence;

2.5.2.8.8.3. Accessibility and accommodations;

2.5.2.8.8.4. Independent living and recovery and wellness principles; and

2.5.2.8.8.5. Information about LTSS programs, eligibility for these services, and program limitations.

2.5.2.8.8.6. Coordination with counties on IHSS.

2.5.2.8.9. Nothing in this contract shall be construed as requiring the Enrollee to participate on the ICT. The

Contractor shall allow the Enrollee to opt-out of the ICT at any time and the ICT shall be able to continue its operations. Enrollees may not be disenrolled for lack of participation on the ICT. Criteria for disenrollment are discussed in Section 2.3.2.

2.5.2.8.10. If an Enrollee refuses an ICT, at a minimum the Care Coordinator must provide his or her contact information to the Enrollee and re-visit the refusal at the time of reassessment, or if the Enrollee's PCP changes.

2.5.2.8.11. The administration of the ICT will also follow all applicable current DPLs.

2.5.2.9. Individual Care Plan (ICP). Contractor will develop an ICP for each Enrollee. Contractor will regularly engage Enrollees and/or their representatives in the design, reassessment and updates of the ICPs.

2.5.2.9.1. Enrollees or their authorized representative must have the opportunity to review and sign the ICP and any of its amendments. Contractor must provide Enrollees with copies of the ICP and any of its amendments. The ICP must be made available in alternative formats and in an Enrollee's preferred written or spoken language.

2.5.2.10. If an Enrollee refuses to be involved in ICP development, the Contractor must seek to re-visit the refusal at least at the time of reassessment, or if the Enrollee's PCP changes.

2.5.2.11. ICPs will include:

2.5.2.11.1. The name and contact information for the Enrollees current, assigned Care Coordinator. Enrollee service numbers may be used only if the number will transfer the Enrollee to her/his assigned Care Coordinator;

2.5.2.11.2. The name and contact information for the Enrollee's PCP and any specialists;

2.5.2.11.3. A complete, current list of the Enrollee's medications;

2.5.2.11.4. Enrollee goals, preferences, choices and abilities;

2.5.2.11.5. Measurable objectives and timetables to meet medical, Behavioral Health services, and LTSS needs as determined through the HRA, Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS) records, behavioral health utilization, other data, self and provider referrals, and input from members of the ICT, as appropriate;

2.5.2.11.6. Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies, when appropriate;

2.5.2.11.7. Timeframes for reassessment and updating of Care Plan, to be done at least annually or if a significant change in condition occurs;

2.5.2.11.8. If the Enrollee is receiving Behavioral Health services, the ICP will also include:

2.5.2.11.8.1. The name and contact information of the primary county or county-contracted Behavioral Health provider;

2.5.2.11.8.2. Attestation that the county Behavioral Health provider and PCP have reviewed and approved the ICP; and

2.5.2.11.8.3. Record of at least one (1) case review meeting that included the county Behavioral Health provider and includes date of meeting, names of participants, and evidence of creation or adjustment of care goals.

2.5.2.11.9. If the Enrollee is receiving IHSS, the ICP should also include:

2.5.2.11.9.1. The name and contact information for the county social worker with the responsibility for authorizing and overseeing IHSS hours; and

2.5.2.11.9.2. The name and contact information for the IHSS worker.

2.5.2.11.10. Additional components discussed in current and applicable DPLs consistent with Section 2.1.5.

2.5.2.12. The Contractor will transfer, to another MMP, or its designated Contractor for Enrollees, information necessary to support continuity of care when an Enrollee transfers to another MMP. This information includes, but is not limited to, assessment, ICP, and other pertinent information.

2.5.2.12.1. The information shall be provided no later than thirty (30) calendar days from receipt of the notice of disenrollment to the Contractor and in theformat specified by DHCS and CMS.

2.5.2.12.2. This data sharing package and process will be subject to CMT approval following a joint planning process in the first half of 2018 with CMS, DHCS, and the Contractor.

2.5.2.12.2.1. Detail regarding data transfer methods, the content of the transfer package, look back periods, eligible beneficiaries, and other transfer specifics will be determined via this planning process

2.5.2.13. Basic Case Management. The PCP and/or Care Coordinator, in collaboration with the Contractor, will provide basic case management services.

2.5.2.13.1. Enrollees may choose to refuse any treatment, including case management.

2.5.2.13.2. Basic case management services include:

2.5.2.13.2.1. A review of clinical information from the provider;

2.5.2.13.2.2. Completion of the HRA. (see Section 2.8);

2.5.2.13.2.3. Creation of the ICP, in collaboration with the ICT (see Section 2.8.3);

2.5.2.13.2.4. Identification and referral to appropriate providers and facilities, such as medical, rehabilitation, support services, LTSS,

Behavioral Health, Care Plan Option Services, and for covered and non-covered services;

2.5.2.13.2.5. Direct communication with Enrollee, Enrollee providers, and family;

2.5.2.13.2.6. Enrollee and family education, including health lifestyle changes when warranted (see Section 2.9.11.8); and

2.5.2.13.2.7. Coordination of services outside of the Cal MediConnect Plan, such as referral to appropriate community social services, specialty mental health, Drug Medi-Cal services, IHSS service agencies or Medi-Cal Dental.

2.5.2.14. Complex Case Management. Contractor will develop methods to identify Enrollees who may benefit from complex case management services, using the risk stratification and HRA results (see sections 2.8.1 and 2.8.2) as well as utilization and clinical data and any other available information across medical, LTSS, and Behavioral Health domains, as well as self and provider referrals.

2.5.2.14.1. Complex case management services will include:

2.5.2.14.1.1. Basic case management services (see Section 2.5.2.13 et. seq.)

2.5.2.14.1.2. Management of acute or chronic illness

2.5.2.14.1.3. Intense coordination of resources to ensure Enrollee maintains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline, and avoids institutionalization when appropriate and possible.

2.5.2.15. Coordination of Care Management. Contractor shall coordinate with external organization(s) for provision of Covered Services (described in Appendix A) as appropriate for the Enrollee (see Sections 2.6 and 2.7).

2.5.2.15.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollee to MSSP organization for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

2.5.2.15.2. Contractor shall develop and implement processes for coordination of care for nursing facility residents, including care transition plans and programs to move Enrollees back into the community to the extent possible, in accordance with WIC section 14182.17(d)(4)(H) and in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

2.5.2.16. Coordination of Care Management with external organization for provision of IHSS as appropriate for the Enrollee.

2.5.2.16.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollees to county IHSS agency for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

2.5.2.17. Care Plan Option Services. A CPO Service is optional under the Enrollee's ICP. See Section 2.4.3.

2.5.2.18. Annual Evaluation of Care Management Program. Contractor will conduct annual review, analysis, and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services.

2.5.2.18.1. Contractor will have a process for developing a corrective action plan, with specified timelines, for any out of compliance findings.

2.5.2.19. Discharge Planning and Care Coordination. Contractor shall ensure provision of discharge planning when Enrollee is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are

in place in the community for the Enrollee once he or she is discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee and/or caregiver. Minimum criteria for discharge planning checklist must include:

2.5.2.19.1. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received. Documentation of pre-discharge factors, including an understanding of the medical condition or functional status by Enrollee or a representative of the Enrollee as applicable, physical and mental health status, financial resources, and social supports.

2.5.2.19.2. Per current and applicable DPLs regarding discharge planning, services needed after discharge, type of placement preferred by the Enrollee/representative of the Enrollee and hospital/institution, type of placement agreed to by the Enrollee/representative of Enrollee, specific agency/home recommended by the hospital, specific agency/home agreed to by the Enrollee/representative of the Enrollee, and pre-discharge counseling recommended.

2.5.2.19.3. Post-transition discharge policies and procedures will cover criteria to include, but not limited to, access to necessary medical care and follow up, medications, durable medical equipment and supplies, transportation, and integration of community based LTSS programs, as well as coordination with IHSS services authorized by the counties.

2.5.2.19.4. Coordination, as appropriate, with: 1) county agencies for IHSS and Behavioral Health services (through social worker and providers, as needed); 2) MSSP providers; 3) CBAS centers; 4) community organizations such as Area Agencies on Aging and DHCS Care Transition projects; 5) LTSS providers, including nursing facilities; 6) specialized providers (including, but not limited to specialists, pharmacists, physical/occupational therapists; 7) Medi-Cal Dental and, 8) others as deemed appropriate. For IHSS, the

Contractor's coordination process must be developed jointly with county social service agencies and consider State requirements for counties regarding discharge planning.

2.5.2.19.5. Policies and procedures governing expedited MSSP assessment and eligibility determination as part of the Contractor's Care Coordination process for Enrollees who are being discharged from the hospital or at risk of immediate placement in a SNF.

2.5.2.19.6. Summary of the nature and outcome of Enrollee involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

2.5.2.19.7. For Enrollees receiving Behavior Health services, Contractor will have procedures developed jointly with the MHP for:

2.5.2.19.7.1. Notification of the ICT of hospital admission (psychiatric or acute) and coordinating a discharge plan, if applicable.

2.5.2.19.7.2. Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address an Enrollee's medical problems based on changes in the Enrollee's mental health or medical condition.

2.5.2.20. In addition to the oversight of plan complaints, Grievances, and Cal MediConnect Ombuds Program activity via the CMT, the Contractor shall include ombudsman reports in quarterly updates to local advisory convenings and shall participate in all statewide stakeholder and oversight convenings as delineated in DPLs.

2.6. Long-Term Services and Supports (LTSS).

2.6.1. Contractor will ensure access to, provision of, and payment for: 1) CBAS for Enrollees who meet eligibility criteria for CBAS as defined in Section 2.6.1.1.1, and 2), MSSP for Enrollees who meet the eligibility

criteria for MSSP pursuant to Welfare and Institutions Code section 9560.

2.6.1.1. Community Based Adult Services (CBAS): The Contractor shall contract for CBAS, which is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Enrollees.

2.6.1.1.1. The Contractor shall make available the CBAS benefit to Enrollees who are age twenty-one (21) or older and derive their Medi-Cal eligibility from the State Plan, are Medicare beneficiaries, are either aged, blind, or disabled and who qualify based on the following criteria.

2.6.1.1.1.1. Meet medical necessity criteria as established by the State and meet "Nursing Facility Level of Care A" (NF-A) criteria, as set forth in the DHCS Code of Regulations, or above NF-A Level of Care; or

2.6.1.1.1.2. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, stages 5, 6, or 7 of the Alzheimer's Type; or

2.6.1.1.1.3. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer's Type, and needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;

2.6.1.1.1.4. Have a Chronic Mental Disorder or acquired, organic, or traumatic brain injury. In addition to the presence of a Chronic Mental Disorder or acquired, organic, or traumatic brain injury, the Enrollee shall need assistance or supervision with either:

2.6.1.1.1.4.1. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

2.6.1.1.1.4.2. One (1) need from the above list and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

2.6.1.2. Multi-purpose Senior Services Program (MSSP): A program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

2.6.1.2.1. Contractor shall inform its Enrollees about the MSSP and establish a mechanism to refer Enrollees who are enrolled in Cal MediConnect and are potentially eligible for the MSSP to MSSP providers for eligibility determination.

2.6.1.2.2. Care Coordination – Contractor shall coordinate and work collaboratively with MSSP providers on Care Coordination activities surrounding the MSSP Waiver Participant including, but not limited to: coordination of benefits between Contractor and MSSP provider to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

2.6.1.2.3. For Enrollees that may qualify for MSSP, but are on the waiting list, the Contractor may provide alternate services as identified through the development of the ICP as described in Sections 2.5.2.11.7 and 2.8.3.

2.6.2. The Contractor will ensure referral to IHSS for Enrollees who meet the eligibility criteria for IHSS pursuant to Welfare and Institutions Code section 12305.6.

2.6.2.1. In-Home Supportive Services (IHSS): A program that serves aged, blind, or disabled persons who are unable to perform activities of daily living and cannot remain safely in their

own homes without help pursuant to the California Welfare and Institutions Code (commencing with section 12300) of Chapter 3, and sections 14132.95, 14132.952, and 14132.956.).

2.6.2.1.1. Contractor will coordinate with county agencies to facilitate IHSS participation on the ICT. Contractor will ensure Network Providers coordination with IHSS.

2.6.2.1.2. Contractor will coordinate with county agencies to develop and implement detailed processes for coordination and integration of IHSS which shall include, but not be limited to:

2.6.2.1.2.1. Provision of intake activities and redeterminations by IHSS social workers and allocation of IHSS hours according to WIC section 12301.1 and how that information is coordinated and shared with the ICT.

2.6.2.1.2.2. Framework for referrals to IHSS county agencies, coordination for change of condition, discharge planning, reassessments, and the ICT.

2.6.2.1.3. DHCS and CDSS will continue to provide the Contractor with IHSS assessment data.

2.6.3. Nursing Facilities

2.6.3.1. Contractor shall contract with SNFs, as defined in California Code of Regulations Title 22 section 51121(a), in its Service Area that are licensed by California Department of Public Health (CDPH) and certified by DHCS for participation as a SNF in the Medi-Cal Program and additional Contractor credentialing standards, if any. See Section 2.10.2.3.

2.6.3.2. If SNFs beds are not available in the Contractor's Service Area, Contractor shall contract with qualified SNFs in areas outside of the Contractor's Service Area, in correspondence to the Contractor's projected need for SNF beds of its Enrollees.

2.7. Coordinated Primary Care and Behavioral Health.

2.7.1. Contractor shall provide Enrollee access to Behavioral Health services covered by Medicare and Medi-Cal with a focus on the Recovery Model (See Covered Services in Appendix A). Coordination of Behavioral Health services financed and administered by county agencies shall include at a minimum the following:

2.7.1.1. Contractor will develop and implement a plan to ensure seamless access, coordination and delivery of Covered Services that are Medically Necessary to Enrollees who meet the medical necessity criteria.

2.7.1.1.1. To determine responsibility for covering Medi-Cal Specialty Mental Health Services, the Contractor and county will follow the medical necessity criteria for specialty mental health 1915(b) waiver services described in the California Code of Regulations Title 9 sections 1820.205, 1830.205, and 1830.210. The outpatient criteria can be summarized as the following three criteria: 1) diagnosis – one or more of the specified diagnoses; 2) impairment – significant impairment or probability of deterioration of an important area of life functioning; or; 3) intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to a physical health care based treatment.

2.7.1.1.2. To determine medical necessity for Drug Medi-Cal Benefits, Contractor and counties will follow California Code of Regulations Title 22 sections 51303 and 54301. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in California Code of Regulations Title 22 section 51159.

2.7.1.1.3. To determine medical necessity for the authorization of Covered Services that become Medi-Cal managed care Behavioral Health Services on January 1, 2014, pursuant to Welfare and Institutions Code section 14132.03, the Contractor shall use medical necessity criteria set forth current and applicable DPL(s) as described in Section 2.1.5.

2.7.1.2. Contractor will have a Memorandum of Understanding (MOU) with county agencies that finance and administer Behavioral Health services. The MOU must be approved by CMS and DHCS. It will include:

2.7.1.2.1. Service Coordination: Contractor will include comprehensive screening for Behavioral Health as part of the HRA (see Section 2.8.2.2) and ICP (see Section 2.8.3). The local MOU will describe:

2.7.1.2.1.1. Delineation of clinical responsibilities and provider contracting responsibilities;

2.7.1.2.1.2. Point of contact within the Cal MediConnect Plan and county entity(ies) and the various communications processes to address issues related to clinical coordination, including pharmaceutical coordination;

2.7.1.2.1.3. A process for resolving disagreements related to clinical decision making, administrative, and policy issues;

2.7.1.2.1.4. Standardized approaches to screening, referral, and linkages and coordination for mental health and substance use services with timelines specified; and

2.7.1.2.1.5. Processes for clinical consultation and coordination of ICPs.

2.7.1.2.2. Administrative coordination: Contractor will clearly delineate administrative responsibilities and provider contracting responsibilities, including:

2.7.1.2.2.1. Point of contacts and communication processes to address administrative coordination;

2.7.1.2.2.2. Process for annual review and evaluation of administrative management programs; and

2.7.1.2.2.3. Process for demonstrating how administrative problem identification and resolution occurs.

2.7.1.2.3. Information exchange: Contractor will develop data sharing mechanisms with the county Behavioral Health agencies, to the greatest extent practicable under State and federal Privacy laws, to share accurate and timely information to inform care delivery. It will describe:

2.7.1.2.3.1. Information flow between Contractor and county agencies; and

2.7.1.2.3.2. Processes for exchange of health information.

2.7.1.2.4. Performance measures: Contractor is required to report on measures related to Behavioral Health services for which they have direct contracts with providers including Medicare Behavioral Health benefits.

2.7.1.2.4.1. Contractor is required to show evidence of data sharing agreement with county agencies that provide Medi-Cal Behavioral Health services. The data sharing agreements shall provide for the exchange of data in compliance with all applicable State and federal laws.

2.7.1.2.4.2. Shared financial accountability is discussed in Section 4.7.4.

2.8. Health Risk Assessments, ICP, and Care Coordination

2.8.1. Risk Stratification. Contractor will use an approved health risk stratification mechanism or algorithm to identify new Enrollees with high risk and more complex health care needs. The health risk stratification shall be conducted in accordance applicable DPL(s) as indicated in Section 2.1.5

2.8.1.1. Contractor shall use the following data sources to identify an Enrollees' risk level.

2.8.1.1.1. Medicare utilization data, including Medicare Parts A, B, and D.

2.8.1.1.2. Medi-Cal utilization data, including IHSS, MSSP, SNF, and Behavioral Health pharmacy data.

2.8.1.1.3. Results of previously administered assessments.

2.8.1.1.4. Other population- and individual-based tools.

2.8.2. Health Risk Assessment (HRA). In accordance with all applicable federal and State laws WIC section 14182.17(d)(2), and in accordance with applicable DPL(s) as indicated in Section 2.1.5. Contractor will complete HRAs for all Enrollees.

2.8.2.1. The HRA will serve as the starting point for the development of the ICP.

2.8.2.2. For all Enrollees, the assessment process will, at a minimum, identify:

2.8.2.2.1. Referrals to appropriate LTSS and home- and community-based services;

2.8.2.2.2. Caregivers, Enrollees, and authorized representatives participation;

2.8.2.2.3. Facilitation of timely access to primary care, specialty care, DME, medications, and other health services needed by the Enrollee, including referrals to resolve physical or cognitive barriers to access;

2.8.2.2.4. Facilitation of communication among the Enrollee's providers, including Behavioral Health providers as appropriate;

2.8.2.2.5. Identification of the need for providing other activities or services needed to assist Enrollees in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and

2.8.2.2.5.1. Support for Enrollees who need more complex case management, as described in Sections 2.5.2.14 and 2.5.2.15.

2.8.2.2.5.2. Other elements in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.2.3. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of

enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.2.4. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5

2.8.2.5. Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a HRA within the time period set forth above and whom Contractor has been unable to contact. Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

2.8.2.6. Reassessments will be conducted at least annually, within twelve (12) months of last assessment, or as often as the health and/or functional status of the Enrollee requires.

2.8.2.6.1. When determining the mode for completing reassessment, the Contractor will consider the reason the assessment needs to be updated, the Enrollee's needs and health or functional status, and the preference of the Enrollee.

2.8.2.7. Contractor will regularly use electronic health records and claims data to inform reassessments and to identify Enrollees at high risk, with newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or Behavioral Health referral.

2.8.3. Individualized Care Plan (ICP). A comprehensive, person-centered ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment. See Section 2.5.2.11.7.

2.8.3.1. The Contractor must complete the ICP within ninety (90) calendar days of enrollment.

2.8.3.2. The Contractor will provide the ICP to the Enrollee no less than annually.

2.8.4. Continuity of Care. Contractor shall ensure Enrollees continue to have access to medically necessary items, services, and medical and LTSS providers as described below and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.4.1. Contractor must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:

2.8.4.1.1. A period up to twelve (12) months for Medicare services if all of the following criteria are met under WIC section 14132.275(l)(2)(A):

2.8.4.1.1.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network PCP or specialist at least once within the previous twelve (12) months from the date of enrollment The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medicare data provided by DHCS or by documentation by the provider or Enrollee;

2.8.4.1.1.2. Provider is willing to accept payment from the Contractor based on the current Medicare fee schedule; and

2.8.4.1.1.3. Contractor would not otherwise exclude the provider from its Provider Network due to documented quality of care concerns or State or federal exclusion requirements.

2.8.4.1.2. A period of up to twelve (12) months for Medi-Cal services if all of the following criteria are met under Welfare and Institutions Code section 14182.17(d)(5)(G).

2.8.4.1.2.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network provider at least once within the previous

twelve (12) months from the date of enrollment. The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medi-Cal FFS claims, treatment authorization request data or Medi-Cal managed care Encounter Data provided by the State or by documentation from the provider or Enrollee.

2.8.4.1.2.2. Provider is willing to accept payment from the Contractor based on the Contractor's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and

2.8.4.1.2.3. Contractor would not otherwise exclude the provider from their Provider Network due to documented quality of care concerns or State or federal exclusion requirements.

2.8.4.1.3. Enrollees will not be required to change nursing facilities during the duration of the Demonstration if they resided in the nursing facility prior to enrollment in MediConnect, the facility is licensed by CDPH, meets acceptable quality standards, and the facility and Contractor agree to rates in accordance with Section 2.8.4.1.2.2.

2.8.4.1.4. Sections 2.8.4.1.1 and 2.8.4.1.2 do not apply to providers of the following: durable medical equipment, medical supplies, transportation, other ancillary services, or carved-out services.

2.8.4.1.5. Contractor must inform Enrollees of its new Network Providers.

2.8.4.1.6. If an Enrollee receives care from an out-of-network provider, Contractor must advise the Enrollee and provider that they have received care from an out-of-network provider that would not otherwise be covered at an in-network level.

2.8.4.1.7. Part D transition rules and rights will continue as provided for in current law and regulation for the

entire integrated formulary associated with the Cal MediConnect Plan.

2.8.4.1.8. The DHCS will distribute an enrollment choice packet that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment choice packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

2.8.4.1.8.1. Contractors in COHS will distribute an enrollment package that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

2.8.4.1.9. Out of Network Reimbursement Rules – For reimbursement of out-of-network Emergency Services or Urgent Care services, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, the Health Care Professional is required to accept as payment in full by the Contractor the amounts that the Health Care Professional could collect for that service if the beneficiary were enrolled in original Medicare or Medi-Cal FFS. However, the Contractor is not required to reimburse the Health Care Professional more than the Health Care Professional's charge for that service. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the Contractor in writing that it is billing an amount less than such amount. For Emergency Services and postabilization care services, as defined by 42 C.F.R. § 438.114(a), for which Medi Cal is the primary payor, the Contractor must comply with 42 C.F.R. § 438.114 and an out-of-network provider is required to accept the applicable Medi-Cal fee-for-service payment

amount as payment in full by the Contractor consistent with 42 U.S.C. § 1396u-2(b)(2)(D). Enrollees maintain balance billing protections as provided in Section 5.1.12.

2.8.4.1.9.1. Contractors may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which the Contractor shall pay non-contracted Health Care Professionals and section 1861(u) providers of services the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers) regardless of setting and type of care for authorized out-of-network services.

2.8.4.1.10. If an Enrollee is receiving any service that would not otherwise be authorized by the Contractor after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period that the service will no longer be authorized, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.4.1.11. The Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the Contractor's formulary but require prior authorization or step therapy under the Contractor's utilization management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.8.4.1.12. If Contractor's Provider Network is unable to provide necessary services covered under the Contract to a particular Enrollee, Contractor must adequately and timely cover these services out of network for the

Enrollee, for as long as the Contractor is otherwise unable to provide them, as required by 42 C.F.R § 438.206(b)(4).

2.9. Provider Network

2.9.1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and the State to ensure adequate access to medical, Behavioral Health, pharmacy, and LTSS, excluding IHSS, providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access.

2.9.2. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including Behavioral Health services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A).

2.9.2.1. Contractor will be required to comply with 42 C.F.R. § 438.56(d)(2).

2.9.3. The Contractor must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) days, following a change in Contractor's Provider Network that renders Contractor unable to provide one (1) or more Covered Services within the access to care standards set forth in Section 2.10.2, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.

2.9.4. The Contractor must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

2.9.5. The Contractor shall assure that all network providers that provide Medicare Covered Services do not appear on the CMS preclusion list in order to receive reimbursement for claims or otherwise participate in the Medicare program. Pursuant to 42 C.F.R. § 438.602(b), the Contractor shall ensure that all such providers are enrolled with DHCS as Medicaid providers consistent with the provider screening, disclosure, and enrollment requirements of 42 C.F.R. 455, subparts B and E. Payment of a portion of a Medicare Covered Service is not considered a Medicaid Covered Service for the purpose of this section.

2.9.6. The Contractor may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act; this does not include IHSS providers.

2.9.7. The Contractor may also offer single-case out-of-network agreements to providers who are: 1) not willing to enroll in the Contractor's Provider Network, 2) currently serving Enrollees, 3) willing to continue serving them at the Contractor in-network rate of payment, under the following circumstances:

2.9.7.1. The Contractor's Provider Network does not have an otherwise qualified Network Provider to provide the services within its Provider Network, or transitioning the care in-house would require the Enrollee to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the Enrollee's condition;

2.9.7.2. Transitioning the Enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or

2.9.7.3. Transitioning the Enrollee to another provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.

2.9.8. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, person who is homeless, Enrollees with disabilities, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf and blind.

2.9.8.1. Contractor shall have a cultural and linguistic services program that incorporates the requirements of California Code of Regulations Title 22 section 53876 regardless of whether it operates in a Two-Plan County. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update its cultural and linguistic services consistent

with the group needs assessment requirements as specified by DHCS.

2.9.8.2. Contractor shall implement and maintain a written description of its cultural and linguistic services program, which shall include at minimum the following:

2.9.8.2.1. An organizational commitment to deliver culturally and linguistically appropriate health care services;

2.9.8.2.2. Goals and objectives;

2.9.8.2.3. A timetable for implementation and accomplishment of the goals and objectives;

2.9.8.2.4. An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the community advisory committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described; and

2.9.8.2.5. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

2.9.8.3. Linguistic Capability of Employees: Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

2.9.8.4. The Contractor shall educate Network Providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and federal law to communicate with Enrollees with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations.

2.9.8.5. The Contractor shall ensure that multilingual Network Providers and, to the extent that such capacity exists within the Contractor's Service Area, all Network Providers,

understand and comply with their obligations under Sate or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

2.9.8.6. The Contractor shall ensure that Network Providers have interpreters/translators that are available for those who are deaf or hearing-impaired within the Contractor's Service Area.

2.9.8.7. The Contractor shall ensure that its Network Providers are responsive to the unique linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of Enrollees, including Enrollees who are homeless, disabled (both congenital and acquired disabilities) and other special populations served under the Contract.

2.9.8.8. The Contractor shall ensure that its Network Providers have an understanding of disability-competent care.

2.9.8.9. Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 (42 U.S.C. Section 12101 et seq.), 45 C.F.R. Part 84 and 28 C.F.R. Part 36. Title IX of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.

2.9.9. Provider Qualifications and Performance

2.9.9.1. All Network Providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medi-Cal programs and a valid NPI number, as applicable. Providers that have been terminated from or suspended either Medicare or Medi-Cal cannot participate in Contractor's Provider Network.

2.9.9.1.1. Contractor is responsible for the oversight of all Network Providers delivering non-Covered Services (e.g., CPO Services).

2.9.10. Subcontracting Requirements

2.9.10.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.9.10.2. Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective First Tier, Downstream or Related Entity's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements per this Contract and 42 C.F.R. §§ 422.504(i), 423.505(i), 438.230(b)(3), (4) and California Code of Regulations Title 22 section 53867.

2.9.10.3. All contracts entered into with First Tier, Downstream and Related Entities shall be in writing and in accordance with the requirements of the 42 C.F.R. § 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code section 1340 et seq.; Title 28, CCR Section 1300 et seq.; WIC Section 14200 et seq.; Title 22, CCR Section 53800 et seq.; and other applicable federal and State laws and regulations, including the required contract provisions between the Contractor and First Tier, Downstream and Related Entities in Appendix C.

2.9.10.4. The Contractor remains fully responsible for functions delegated and for ensuring adherence to the legal responsibilities under the Contract, as described in Appendix C, except that the Contractor's legal responsibilities under this Contract for the provision of LTSS shall be limited as set forth in WIC sections 14186 through 14186.4.

2.9.10.5. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor. Additional required contract provisions between the Contractor and First Tier, Downstream and Related Entities is contained in Appendix C.

2.9.10.6. The Contractor must:

2.9.10.6.1. Establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees;

2.9.10.6.2. Contract only with qualified or licensed providers who continually meet federal and State requirements, as applicable, and the qualifications contained in Appendix C.

2.9.10.6.3. This section does not apply to the California Department of Social Services or any other State department contracting with the Contractor for the provision of services under the Demonstration.

2.9.11. Provider Education and Training

2.9.11.1. Provider Education. Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Network Provider education regarding Contractor policies and procedures as well as the Cal MediConnect program and the Contractor model of care.

2.9.11.2. Provider Training. Contractor shall ensure that all Network Providers receive training regarding the Cal MediConnect Program in order to operate in full compliance with the Contract and all applicable federal and State statutes and regulations, including rights and responsibilities pertaining to Grievance and Appeals procedures and timelines under this contract. Contractor shall ensure that Network Provider training relates to Cal MediConnect services-including but not limited to the care coordination benefit, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among Contractor, Network Provider, Enrollee and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within thirty (30) working days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that Network Provider training includes information on all Enrollee rights including the right to full disclosure of health care information and the right to actively participate in

health care decisions. The Contractor will maintain policies and procedures on Advance Directives pursuant to 42 C.F.R. §§ 422.128, 438.3(j), and 489.102, and will educate its Network Providers concerning its policies and procedures on Advance Directives. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.

2.9.11.2.1. Contractor shall develop and implement a process to provide information to Network Providers and to train Network Providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction. This process shall include an educational program for Network Providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

2.9.11.3. Provider Orientation. Contractor shall conduct orientation sessions for Network Providers and their office staff.

2.9.11.4. Cultural Competency Training. Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers and First Tier, Downstream and Related Entities with direct Enrollee interaction. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; and, language and literacy needs including limited English proficiency; and diverse cultural and ethnic backgrounds.

2.9.11.5. Provider Manual. The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, claims and encounter submission processes, continuity of care requirements, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, care management programs and Enrollee rights.

2.9.11.5.1. Except as otherwise required or authorized by CMS, DHCS or by operation of law, ensure that Network Providers receive thirty (30) days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Network Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

2.9.11.6. Provider Directory. Contractor shall make its Provider Directory available to Providers via Contractor's web-portal and as described in Section 2.17.5.10.

2.9.11.7. Provider-based Health Education for Enrollees. Contractor shall encourage Network Providers to provide health education to Enrollees as described in Section 2.9.11.8. Contractor shall ensure that Network Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care.

2.9.11.8. Health Education. Contractor shall implement and maintain a health education program that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Enrollees. This includes helping the Enrollee understand their health plan and the benefits the plan provides.

2.9.11.8.1. Contractor shall ensure administrative oversight of the health education program by a qualified full-time health educator.

2.9.11.8.2. Contractor shall provide health education programs and services at no charge to Enrollees directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Enrollee population.

2.9.11.8.3. Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for

Enrollees and effective in achieving behavioral change for improved health.

2.9.11.8.4. Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.

2.9.11.8.5. Contractor shall maintain a health education program that provides educational interventions addressing the following health categories and topics:

2.9.11.8.5.1. Appropriate use of health care services – e.g., managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.

2.9.11.8.5.2. Risk-reduction and healthy lifestyles – e.g., tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity.

2.9.11.8.5.3. Self-care and management of health conditions – e. g., pregnancy; asthma; diabetes; and, hypertension.

2.9.11.8.6. Contractor shall ensure that Enrollees receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist Network Providers in the delivery of health education services for Enrollees.

2.9.11.8.7. Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness, as approved by the Contractor's quality improvement committee.

2.9.11.8.8. Contractor shall periodically review the health education program to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

2.9.11.9. Health, Safety and Welfare Education. As part of its Provider education, Contractor shall include information related to identifying, preventing and reporting abuse, neglect, exploitation, and critical incidents.

2.9.11.10. Disability Sensitivity Training. As part of its Provider education, Contractor shall provide disability sensitivity training for its medical, Behavioral Health, MSSP and CBAS providers. (see Section 2.9.8.8).

2.10. Network Management

2.10.1. General requirements. The Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Covered Services in the Contract. Section 2.9.1 discusses the annual network review and approval requirement.

2.10.1.1. Taking into consideration:

2.10.1.1.1. The anticipated number of Enrollees;

2.10.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

2.10.1.1.3. The number and types of providers required to furnish the Covered Services;

2.10.1.1.4. The number of Network Providers who are not accepting new patients; and

2.10.1.1.5. The geographic location of Network Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.

2.10.1.2. The Contractor will work in collaboration with Network Providers to actively improve the quality of care provided to

Enrollees, consistent with the quality improvement goals and all other requirements of this Contract.

2.10.1.3. The Contractor shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contractor's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor's network pharmacies in its Service Area are open, (e.g., Contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:

2.10.1.3.1. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.10.1.3.2. Eighty (80) percent of incoming calls answered within thirty (30) seconds.

2.10.1.3.3. Disconnect rate of all incoming calls not to exceed five (5) percent.

2.10.2. Access to Care Standards. The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

2.10.2.1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-

Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.html);

2.10.2.2. For Medicare pharmacy providers, time, distance and minimum number as required in Appendix E, Article II, Section I and 42 C.F.R. § 423.120; or

2.10.2.3. For Medi-Cal providers and facilities, the Contractor contract with a sufficient number of LTSS providers, including but not limited to SNFs (distinct part and free-standing), MSSP, CBAS and County Social Services Agencies located in the Contractor's Service Area.

2.10.2.3.1. If the LTSS provider within the Service Area cannot meet the Enrollee's medical needs, the Contractor must contract with the nearest LTSS provider outside of the covered Service Area. Contractor is responsible for all Covered Services, pursuant to WIC section 14186.3(c).

2.10.2.3.2. Contractor shall ensure the provision of acceptable accessibility standards in accordance with 42 C.F.R. §§ 438.206(c) and 438.68 and Title 28 CCR Section 1300.67.2.2 and as specified below.

2.10.2.4. Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medi-Cal fee-for-service, if the provider serves only Medi-Cal Enrollees.

2.10.3. Appropriate Clinical Timeframes. Except for LTSS, Contractor shall communicate, enforce, and monitor providers' compliance with these standards:

2.10.3.1. Contractor shall ensure that Enrollees are offered appointments for covered health care services within a time period appropriate for their condition.

2.10.3.2. Enrollees must be offered appointments within the following timeframes:

2.10.3.2.1. Urgent Care appointment for services that do not require prior authorization – within forty-eight (48) hours after request;

2.10.3.2.2. Urgent appointment for services that do require prior authorization within ninety-six (96) hours after request;

2.10.3.2.3. Non-urgent primary care appointments – within ten (10) business days after request;

2.10.3.2.4. Appointment with a specialist – within fifteen (15) business days after request;

2.10.3.2.5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within fifteen (15) business days after request.

2.10.3.3. Shortening or Expanding Timeframes: Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Enrollee's medical record that a longer timeframe will not have a detrimental impact on the Enrollee's health.

2.10.3.4. Contractor will monitor providers regularly to determine compliance with the timely access requirements

2.10.3.5. Contractor will take corrective action if it, or its providers, fail to comply with timely access requirements.

2.10.4. PCP Assignment

2.10.4.1. The Contractor will allow each Enrollee to choose his or her PCP to the extent possible and appropriate. If the Enrollee does not select a PCP within thirty (30) calendar days of the effective coverage date, Contractor shall assign that Enrollee to a PCP and notify the Enrollee and the assigned PCP in writing no later than forty (40) calendar days after the Enrollee's coverage date.

2.10.4.2. If an Enrollee does not select a PCP within thirty (30) calendar days of the effective date of coverage date, Contractor shall use FFS utilization data or other data sources, including electronic data, to:

2.10.4.2.1. Establish existing provider relationships for the purpose of PCP assignment, including a specialist or clinic, if an Enrollee indicates a preference for either. Contractor shall comply with all federal and State Privacy laws in the provision and use of this data.

2.10.4.3. Contractor shall notify the PCP that an Enrollee has selected or been assigned to the PCP within ten (10) calendar days from when selection or assignment is completed by the Enrollee or the Contractor, respectively.

2.10.4.4. Contractor shall maintain procedures that proportionately include contracting traditional and safety-net providers in the assignment process for Enrollees who do not choose a PCP.

2.10.4.5. If, at any time, an Enrollee notifies the Contractor of a PCP choice, such choice shall override Enrollee assignment to a PCP in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5. Provider Credentialing, Recredentialing, and Board Certification

2.10.5.1. Credentialing and Recredentialing: Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of physicians including PCPs and specialists in accordance with the DHCS Policy Letter 02-03, check to see if a provider is suspended or excluded suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program pursuant to WIC section 14043.61 and 42 C.F.R. § 455.436;, and adhere to managed care standards at 42 C.F.R. § 422.204. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2.10.5.1.1. Contractor shall ensure those policies and procedures are reviewed and approved by the plan governing body, or designee.

2.10.5.1.2. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2.10.5.2. Credentialing Site Review: A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's Provider Network. If a provider is added to Contractor's Provider Network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5.3. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts: Contractor will use procedures consistent with DHCS policy for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify CMS ninety (90) days prior of any such changes.

2.10.6. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC): Contractor shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Contractor shall reimburse FQHCs and RHCs in accordance with current federal and State laws and regulations. If FQHC and RHCs services are not available in the Provider Network, Contractor shall authorize out-of-network services subject to the prevailing Medicare Advantage payment requirements for out-of-network services.

2.10.6.1. FQHC and RHCs Reimbursements: The Contractor shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of:

2.10.6.1.1. The level and amount of payment that the plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC and RHCs, and

2.10.6.1.2. The amount of cost-sharing that would have been paid to the FQHC for serving the Enrollee if the Enrollee were in Medicare fee-for-service, consistent with how such amounts are included in the Medi-Cal component of the Capitation Rates.

2.10.6.1.3. The intent of these provisions is to ensure that Contractors pay FQHCs and RHCs amounts consistent with Medicare and Medi-Cal managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

2.10.7. IHSS Network. Contractor shall develop and execute an MOU with County Social Services Agency responsible for IHSS that reflects an agreement between the Contractor and County Social Services Agency regarding roles and responsibilities for Cal MediConnect and IHSS. This MOU will specify the role of the county in:

2.10.7.1. Assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, in addition to sharing those assessments with the Enrollee's ICT.

2.10.7.2. Sharing confidential data regarding IHSS authorized hours and services as necessary and as permissible under applicable State and federal law.

2.10.7.3. Determining whether the Enrollees' desires to have his or her IHSS providers involved in care planning or coordination, and if so, obtain express consent from the Enrollee or his or her authorized representative.

2.10.7.4. Support an Enrollee who is at risk for out-of-home placement in obtaining IHSS services.

2.10.7.5. Report documentation that Contractor has developed and will conduct a benefit orientation and training program specific to IHSS for First Tier, Downstream and Related Entities. The Contractor also provides documentation that it has trained personnel of IHSS organizations regarding the Contractor's Covered Services and policies and procedures to access services and coordinate care.

2.10.8. Emergency Services Programs (ESPs)

2.10.8.1. Contractor shall have, as a minimum, a designated emergency service facility, providing care on a twenty-four (24) hour-a-day, seven (7) day-a-week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

2.10.9. Emergency Care

2.10.9.1. Contractor shall cover Emergency Services without prior authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Contractor shall coordinate access to emergency care services in accordance with 42 C.F.R. § 438.114 and the Contractor's DHCS-approved emergency department protocol.

2.10.9.2. Contractor shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-emergency care.

2.10.9.3. Contractor shall ensure that a contracting physician is available twenty-four (24) hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Enrollees in an emergency department, if necessary.

2.10.9.4. Contractor may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2.10.9.5. Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's PCP, MCO, PIHP, PAHP or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

2.10.9.6. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.10.9.7. May not deny payment for treatment obtained under either of the following circumstances:

2.10.9.7.1. An Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition.

2.10.9.7.2. The Contractor's representative instructs the Enrollee to seek Emergency Services.

2.10.9.8. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

2.10.10. Post-Stabilization Care Services

2.10.10.1. The Contractor must cover and pay for Post-Stabilization Care Services.

2.10.10.2. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Contractor's provider or other Contractor representative.

2.10.10.3. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's organization that are not pre-approved by a Network Provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.

2.10.10.4. The Contractor is financially responsible for Post-Stabilization Care Services obtained from within or outside the Contractor that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve, or resolve the Enrollee's stabilized condition if the Contractor:

2.10.10.4.1. Does not respond to a request for pre-approval within one (1) hour;

2.10.10.4.2. Cannot be contacted; or

2.10.10.4.3. Or the Contractor's representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Network Provider is not available for consultation.

2.10.10.4.4. In this situation, the Contractor must give the treating physician the opportunity to consult with a Network Provider and the treating physician may continue with care of the Enrollee until a Network Provider is reached or one of the criteria in 42 C.F.R. § 113(c)(3) is met.

2.10.10.5. The Contractor must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Contractor would charge the Enrollee if he or she had obtained the services through the Contractor.

2.10.10.6. End of Contractor's financial responsibility. The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when:

2.10.10.6.1. A Network Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

2.10.10.6.2. A Network Provider assumes responsibility for the Enrollee's care through transfer;

2.10.10.6.3. Contractor's representative and the treating physician reach an agreement concerning the Enrollee's care; or

2.10.10.6.4. The Enrollee is discharged

2.10.11. Long Term Services and Supports Providers Network

2.10.11.1. Contractor shall develop policies and procedures to train:

2.10.11.1.1. All Contractor staff involved in Care Coordination:

2.10.11.1.1.1. Person-centered planning processes;

2.10.11.1.1.2. Linguistic, cultural, and cognitive competence;

2.10.11.1.1.3. Core concepts of the Olmstead Decision, i.e. serving Enrollees in the least restrictive settings as appropriate;

2.10.11.1.1.4. Accessibility and accommodations; independent living;

2.10.11.1.1.5. Wellness principles;

2.10.11.1.1.6. Criteria for safe transitions, transition planning, Care Plans after transitioning; and,

2.10.11.1.1.7. Along with other required training as specified by DHCS—both initially and on an annual basis.

2.10.11.1.2. Specially designated Care Coordination staff in dementia care management including but not limited to:

2.10.11.1.2.1. Understanding dementia;

2.10.11.1.2.2. Symptoms and progression;

2.10.11.1.2.3. Understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,

2.10.11.1.2.4. Community resources for Enrollees and caregivers.

2.10.11.1.3. Specially designated Care Coordination staff in MSSP including but not limited to:

2.10.11.1.3.1. An overview of the characteristics and needs of MSSP's target population;

2.10.11.1.3.2. MSSP's eligibility criteria;

2.10.11.1.3.3. Assessment and reassessment processes, services, and service authorization process; and,

2.10.11.1.3.4. How to refer Enrollees to MSSP for assessment and eligibility determination.

2.10.11.1.4. All Contractor staff generally on the addition of LTSS and social services to Contractor

operations. For all trainings, Contractor shall meet specifications set by DHCS, document completion of training, and have specific policies to address non completion.

2.10.12. Women's Health Services: Contractor shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventive health care services. Such access may be in addition to the Enrollee's PCP.

2.10.13. Family Planning Provider Network

2.10.13.1. Contractor shall cover family planning services for all Enrollees whether the family planning services are provided by contracted provider or an out-of-network provider.

2.10.13.2. Contractor agrees to abide by 42 C.F.R. § 438.206.

2.10.14. Indian Health Network: The Contractor shall permit Indian Enrollees eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as a PCP if the Indian Health Care Provider has capacity to provide such services regardless of whether the Indian Health Care Provider is in or out of network;

2.10.14.1. The Contractor shall demonstrate that there are sufficient Indian Health Care Providers in the Provider Network to ensure timely access to Covered Services for Indian Enrollees who are eligible to receive services;

2.10.14.2. For services provided prior to January 1, 2018, the Contractor shall pay both network and non-network Indian Health Care Providers who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the DHCS fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the Covered Service provided by a non-Indian health care provider;

2.10.14.3. For services provided on or after January 1, 2018, the Contractor shall reimburse Indian Health Care Providers who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Contractor shall ensure any retroactive outpatient per visit rates are

appropriately reimbursed to the Indian Health Care Provider;

2.10.14.4. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian health care provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

2.10.14.5. When the amount the in-network Indian Health Care Provider receives from the contractor is less than the amount the IHCP would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

2.10.14.6. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians regardless of payer. The Contractor must exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

2.10.14.7. The Contractor must permit an out of network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider.

2.11. Enrollee Access to Services

2.11.1. General. The Contractor must provide services to Enrollees as follows:

2.11.1.1. Authorize, arrange, coordinate and provide to Enrollees all Covered Services that are Medically Necessary;

2.11.1.2. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with

disabilities from obtaining all Covered Services from the Contractor by:

2.11.1.2.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.11.1.2.2. Providing interpreters or translators for Enrollees who are deaf and hard of hearing and those with limited English proficiency;

2.11.1.2.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:

2.11.1.2.3.1. Providing large print (at least 16-point font) versions of all written materials to Enrollees with visual impairments;

2.11.1.2.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.11.1.2.3.3. Reading notices and other written materials to Enrollees upon request;

2.11.1.2.3.4. Assisting Enrollees in filling out forms over the telephone;

2.11.1.2.3.5. Ensuring effective communication to and from Enrollees with disabilities through email, telephone, and other electronic means;

2.11.1.2.3.6. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and

2.11.1.2.3.7. Individualized assistance.

2.11.1.3. The Contractor must identify to DHCS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute a work plan to achieve and maintain ADA compliance; and

2.11.1.4. If the Contractor's Provider Network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them.

2.11.1.5. When a PCP or medical, Behavioral Health or LTSS provider is terminated from the Contractor's plan or leaves the Provider Network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, or no later than thirty (30) calendar days before the termination date, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor must also report the termination to DHCS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.

2.11.1.6. Contractor shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of vacation, illness, or other unforeseen circumstances.

2.11.2. Contractor shall ensure Enrollee access to specialists for Covered Services that are Medically Necessary. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through subcontracts, sufficient to assure that health services will be provided in accordance with Section 2.10.2 and consistent with all specified requirements.

2.11.2.1. Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor Network Providers' compliance with these requirements.

2.11.2.1.1. Appointments: Contractor shall implement and maintain procedures for Enrollees to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

2.11.2.1.2. First Prenatal Visit: Contractor shall ensure that the first prenatal visit for a pregnant Enrollee will be available within two (2) weeks upon request.

2.11.2.1.3. Waiting Times: Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the Network Providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in 2.11.2.1.1 appointments, above.

2.11.2.1.4. Telephone Procedures: Contractor shall require Network Providers to maintain a procedure for triaging Enrollees' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2.11.2.1.5. After Hours Calls: At a minimum, Contractor shall ensure that all Enrollees have access to appropriate licensed professional for after-hours calls.

2.11.2.1.6. Unusual Specialty Services: Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined medically necessary.

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);

2.11.3.1.2. Urgent Care sought outside of the Service Area;

2.11.3.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.11.3.1.4. Preventative services;

2.11.3.1.5. Family planning services;

2.11.3.1.6. Out-of-area renal dialysis services;

2.11.3.1.7. Basic prenatal care;

2.11.3.1.8. Sexually transmitted disease services; and

2.11.3.1.9. HIV testing.

2.11.4. The Contractor must have a mechanism in place to allow Enrollees with special health care needs to have direct access to a specialist as appropriate for the Enrollee's condition and identified needs, such as a standing referral to a specialty Provider.

2.11.5. Authorization of Services. In accordance with 42 C.F.R. § 438.210, the Contractor shall authorize services as follows:

2.11.5.1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:

2.11.5.1.1. Have in place and follow written policies and procedures;

2.11.5.1.2. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions;

2.11.5.1.3. Have in place procedures to allow Enrollees to initiate requests for provision of services; and

2.11.5.1.4. Consult with the requesting Network Provider when appropriate.

2.11.5.2. The Contractor shall ensure that an authorized Care Coordinator is available twenty-four (24) hours a day for timely authorization of Covered Services that are Medically Necessary and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor's guidelines for medical necessity must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medi-Cal standards for LTSS.

2.11.5.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a licensed clinician, acting within their scope of practice, with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.11.5.4. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for quantitative treatment limitations between Behavioral Health and medical/surgical inpatient, outpatient and pharmacy benefits.

2.11.5.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.5.5.1. Be produced in a manner, format, and language that can be easily understood;

2.11.5.5.2. Be made available in Threshold Languages, upon request;

2.11.5.5.3. Include information, in Threshold Languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency: and

2.11.5.5.4. In any written communication to a physician or other health care provider of a denial, delay or modification of a request, include the name and telephone number of the health care professional responsible for the denial, delay or modification.

2.11.5.6. The Contractor must make authorization decisions in the following timeframes:

2.11.5.6.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires, within five (5) working days from receipt of the information reasonably necessary to render a decision, and in all circumstances no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.1.1. The Enrollee or the Provider requests an extension, or

2.11.5.6.1.2. The Contractor can justify (to the satisfaction of DHCS and/or CMS upon request) that:

2.11.5.6.1.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.1.2.2. There is a need for additional information where:

2.11.5.6.1.2.2.1. There is a reasonable likelihood that receipt of such information would

lead to approval of the request, if received; and

2.11.5.6.1.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in Section 2.11.5.6.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.2.1. The Enrollee or the provider requests an extension; or

2.11.5.6.2.2. The Contractor can justify (to DHCS and/or CMS upon request) that:

2.11.5.6.2.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.2.2.2. There is a need for additional information where:

2.11.5.6.2.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.5.6.2.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.3. In accordance with 42 C.F.R. §§ 438.3(i), 438.210(e), and 422.208, compensation to individuals or entities that conduct utilization management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

2.11.6. Utilization Management

2.11.6.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:

2.11.6.1.1. Qualified staff responsible for the utilization management program.

2.11.6.1.2. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

2.11.6.1.3. Allowances for a second opinion from a qualified health professional at no cost to the Enrollee.

2.11.6.1.4. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

2.11.6.1.5. Communications to Network Providers of the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

2.11.6.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

2.11.6.1.7. The quarterly reporting of utilization management activities into the DHCS, including a process to electronically report on the number and types of Appeals, denials, deferrals, and modifications to the appropriate DHCS and CMT staff.

2.11.6.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

2.11.6.1.9. Procedures to identify, communicate, and implement actions to correct potential over and under-utilization issues that are identified.

2.11.6.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. §§ 422.112, 422.152, 422.202, and 422.4.

2.11.6.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.6.3.1. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

2.11.6.3.2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of

medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee or its equivalent.

2.11.6.3.3. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2.11.6.3.4. Reasons for decisions are clearly documented.

2.11.6.3.5. Notification to Enrollees regarding denied, deferred or modified referrals is made.

2.11.6.3.6. Decisions and Appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

2.11.6.3.7. Prior Authorization requirements shall not be applied to Emergency Services, urgently needed services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2.11.6.3.8. Records, including any NOA, shall meet the retention requirements described in Section 5.4 Records Retention, Inspection, and Audit.

2.11.6.3.9. Contractor must notify the requesting provider or Enrollee of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

2.11.7. Timeframes for Authorization

2.11.7.1. Emergency and Urgently Needed Care: No prior authorization required, following the reasonable person

standard to determine that the presenting complaint might be an emergency.

2.11.7.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.7.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto. Retrospective review applies only to Medi-Cal services, but Contractor may at its discretion apply retrospective review to Medicare services.

2.11.7.4. Non Part D covered pharmaceuticals: Twenty-four (24) hours on all drugs that require prior authorization in accordance with WIC section 14185 or any future amendments thereto.

2.11.7.5. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.6. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and not later than seventy-two (72) hours after receipt of the request for

services. The Contractor may extend this period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.7. LTSS Authorization as follows:

2.11.7.7.1. Must include the PCP or case manager signature on any nursing facility authorization or reauthorization request.

2.11.7.7.2. Must include the PCP or case manager signature on any CBAS authorization or reauthorization request.

2.11.7.7.3. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for MSSP to MSSP providers for authorization into the MSSP. MSSP providers and the Contractor shall collaborate and coordinate MSSP care management services (see Section 2.6.1.2).

2.11.7.7.4. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for IHSS to County Social Services Agency responsible for IHSS service authorization. County IHSS eligibility worker may participate on the ICT whenever IHSS services are involved in the care of the Enrollees.

2.11.8. Review of Utilization Data

2.11.8.1. Contractor shall include within the utilization management program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Enrollee utilization patterns shall be reported to DHCS upon request.

2.11.9. Delegating Utilization Management Activities

2.11.9.1. Contractor may delegate utilization management activities. If Contractor delegates these activities, Contractor shall comply with Section 2.11.5.

2.11.10. Availability of Services

2.11.10.1. Access to Services for Emergency Conditions and Urgent Care. The Contractor must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community.

2.11.10.1.1. The Contractor must cover and pay for any services obtained for Emergency Conditions in accordance with 42 C.F.R. § 438.114(c).

2.11.10.1.2. Emergency Medical Treatment and Labor Act (EMTALA): The Contractor and Network Providers must comply with EMTALA, including the requirements for qualified hospital medical personnel to provide appropriate medical screening examinations to any Enrollee who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b); and, as applicable, to provide Enrollees stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.11.10.1.3. An Enrollee who has an Emergency Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.11.10.1.4. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor as responsible for coverage and payment.

2.11.10.1.5. The Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider, the Contractor

or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

2.12. Enrollee Services

2.12.1. Enrollee service representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees regarding medical, behavioral, and LTSS services provided;

2.12.1.2. Be trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats;

2.12.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language (ASL), or through an alternative language device or telephone translation service;

2.12.1.4. Inform callers that interpreter services are free;

2.12.1.5. Be knowledgeable about Medi-Cal, Medicare, the CFAM-MOU, and the terms of the Contract;

2.12.1.6. Be available to Enrollees to discuss and provide assistance with Enrollee Grievances and complaints;

2.12.1.7. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL and how to access those services;

2.12.1.8. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.12.1.9. Demonstrate sensitivity to culture, including disability competent care and the independent living philosophy;

2.12.1.10. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of sixth grade and below, and individualized guidance from ESRs to ensure materials are understood;

2.12.1.11. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor;

2.12.1.12. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.12.1.13. Ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

2.12.1.13.1. Enrollees' rights and responsibilities;

2.12.1.13.2. The procedures for an Enrollee to change plans or to opt out of Cal MediConnect;

2.12.1.13.3. How to access oral interpretation services and written materials in Threshold Languages and alternative formats;

2.12.1.13.4. The identity, locations, qualifications, and availability of Network Providers;

2.12.1.13.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.12.1.13.6. Be able to direct Enrollees to the Medi-Cal Dental program for any fee-for-service dental benefits available from Medi-Cal;

2.12.1.13.7. The procedures available to an Enrollee and Network Provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Benefit Determinations (denials); and

2.12.1.13.8. Additional information that may be required by Enrollees and potential Enrollees to understand the requirements and benefits of the Cal MediConnect.

2.12.2. Enrollee Service Telephone Responsiveness

2.12.2.1. The Contractor must operate a call center during normal business hours seven (7) days a week, consistent with the required Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Enrollee must be able to speak with a live ESR, Monday through Friday, during normal business hours, consistent with the required Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Contractor may use alternative technologies on Saturdays, Sundays, and State and federal holidays (except New Year's Day). The Contractor's ESR's must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five percent (5%). The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.12.3. Coverage Determinations and Appeals Call Center Requirements

2.12.3.1. The Contractor must operate a toll-free call center with live ESRs available to respond to Network Providers or Enrollees for information related to requests for coverage under Medicare or Medi-Cal, and Medicare and Medi-Cal Appeals (including requests for Medicare exceptions and prior authorizations). The Contractor is required to provide immediate access to requests for Medicare and Medi-Cal covered benefits and services, including Medicare coverage determinations and redeterminations, via its toll-free call

centers. The call centers must operate during normal business hours, as specified in the Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Contractor must accept requests for Medicare or Medi-Cal coverage, including Medicare coverage determinations /redeterminations, outside of normal business hours, but is not required to have live Enrollee service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

2.12.3.1.1. Indicates that the mailbox is secure;

2.12.3.1.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);

2.12.3.1.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.12.3.1.4. For Appeals calls, articulates the process, information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Part D Appeal requests and thirty (30) days for other standard Appeal requests.

2.12.4. Enrollee Advisory Committee

2.12.4.1. The Contractor shall establish an Enrollee advisory committee that will provide regular feedback to the Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the Enrollee advisory committee:

2.12.4.1.1. Meets at least quarterly throughout the Demonstration.

2.12.4.1.2. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities. CMS and DHCS reserve the right to review and approve Enrollee membership.

2.12.4.2. The Contractor shall also include Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight convenings as requested by DHCS and/or CMS.

2.13. IHSS Related Complaints, Grievances and Appeals

2.13.1. For Enrollee complaints, Grievances, or Appeals related to IHSS, Contractor must comply with the established Grievance and Appeal process established by CDSS and by the county agencies responsible for IHSS, in compliance with WIC section 10950.

2.14. Enrollee Grievances

2.14.1. Grievance Filing -- The Contractor shall inform Enrollees that they may file a Grievance through either the Contractor or Cal Medi-Connect Ombuds Program for complaints relating to Medicare and Medi-Cal covered benefits and services. Medicare beneficiaries may also file a Grievance through 1-800 Medicare. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main web page pursuant to 42 C.F.R. § 422.504 (a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance regarding Medicare and Medi-Cal covered benefits and services may be filed. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee Grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA.

2.14.2.1. Reporting of plan level Grievances: Contractor shall track and report to DHCS the number and types of inquiries, complaints, Grievances, Appeals, and resolutions related to Cal MediConnect, in compliance with 42 C.F.R. § 438.416 and as described in WIC section 14182.17(e)(4)(E), in the format specified by DHCS in accordance applicable DPL(s) as indicated in Section 2.1.5. DHCS will then make the required information publicly available on DHCS' internet web site.

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a Grievance process consistent with 42 C.F.R. Part 438 Subpart F, under which Enrollees may submit their Grievance regarding all Covered Services and benefits to the Contractor. Contractor shall establish and maintain a Grievance process approved by DHCS under which Enrollees may submit their Grievances regarding all benefits and services, consistent with the Knox-Keene Act, and the regulations promulgated thereunder, Welfare and Institutions Code section 14450 and CCR, Title 22, Section 53260.

2.14.2.1.2. The Contractor must maintain written records of all Grievance activities, and notify CMS and DHCS of all internal Grievances. The Grievance record must include the name of the covered person for whom the Grievance was filed; the name of the Contractor's representative recording the grievance; a general description of the reason for the Grievance; the date received; the date of each review or, if applicable, review meeting; and resolution information including date of resolution. The Grievance record must be accessible to CMS and DHCS upon request.

2.14.2.1.3. The system must meet the following standards:

2.14.2.1.3.1. Timely acknowledgement of receipt of each Enrollee Grievance;

2.14.2.1.3.2. Timely review of each Enrollee Grievance;

2.14.2.1.3.3. Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance;

2.14.2.1.3.4. Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the Grievance to each Enrollee Grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and

2.14.2.1.3.5. Notice to the Enrollee of the disposition of the grievance. The Notice must meet the requirements of 42 C.F.R. § 438.408(d)(1), and must:

2.14.2.1.3.5.1. Be produced in a manner, format, and language that can be easily understood;

2.14.2.1.3.5.2. Be made available in Threshold Languages, upon request;

2.14.2.1.3.5.3. Include information, in the most commonly used languages about how to request translation services and alternative formats; and

2.14.2.1.3.5.4. Include information about availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance with Enrollee Grievances and Appeals in completing any forms or other procedural steps, which shall include interpreter services and toll-

free numbers with TTY/TDD and interpreter capability.

2.14.2.1.3.6. In compliance with 42 C.F.R. § 438.406(b), procedures to ensure that decision makers on Grievances were not involved in previous levels of review or decision-making nor were a subordinate of any such individual, and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.14.2.1.3.6.1. A Grievance regarding denial of expedited resolutions of an Appeal.

2.14.2.1.3.6.2. Any Grievance or Appeal involving clinical issues.

2.14.2.1.3.7. In addition to Grievance logs required by Medicare and Medi-Cal rules and 42 C.F.R. § 438.416, per CA Health and Safety Code section 1368(a)(4)(B) and Title 28 CCR 1300.68(d)(8), the Contractor shall maintain a log of all Exempt Grievances. The log shall be periodically reviewed by the plan and shall include the following information for each Exempt Grievance:

2.14.2.1.3.7.1. The date of the call

2.14.2.1.3.7.2. The name of the complainant

2.14.2.1.3.7.3. The complainant's member identification number

2.14.2.1.3.7.4. The nature of the Grievance

2.14.2.1.3.7.5. The nature of the resolution

2.14.2.1.3.7.6. The name of the plan representative who took the call and resolved the Grievance

2.14.2.1.3.8. Notice to the Enrollee of the disposition of the Grievance.

2.14.3. External Grievance: The Contractor shall inform Enrollees that they may file an external Grievance for Medicare only covered benefits and services through 1-800-Medicare or for Medicare and Medi-Cal covered benefits and services through the Cal MediConnect Ombudsman program. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main web page per 42 C.F.R. § 422.504(a)(15)(ii).

2.14.3.1. The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

2.14.3.2. Consistent with Health & Safety Code Section 1368(b), Contractor, except for non-Knox Keene Act Licensed COHS plans, shall inform Enrollees that they may file an External Grievance for Medi-Cal only covered benefits and services through DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free telephone number, DMHC's TDD line for the hearing and speech impaired, and DMHC's website address pursuant to Health & Safety Code Section 1368.02

2.15. Enrollee Appeals

2.15.1. Integrated Notice of Action— In accordance with 42 C.F.R. §§ 431.206, 438.404 and 42 C.F.R. §§ 422.568-572, the Contractor must give the Enrollee written notice of any Adverse Benefit Determination. Enrollees will be notified of all applicable Cal MediConnect, Medicare and Medi-Cal Appeal rights through a single notice. The form and content of the notice must be approved by CMS and DHCS. The Contractor shall notify the Enrollee of its decision at least ten (10) days in advance of the date of its action.

2.15.1.1. The notice must explain:

2.15.1.1.1. The action the Contractor has taken or intends to take;

2.15.1.1.2. The reasons for the action, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information

relevant to the Enrollee's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

2.15.1.1.3. The citation to the regulations supporting such action

2.15.1.1.4. The Enrollee's, provider's, or authorized representative's right to file an Appeal with the Contractor and whether exhaustion of the Contractor's internal Appeal process is a prerequisite to additional external review from by Medicare, Independent Medical Review by DMHC (if applicable), or a State Fair Hearing;

2.15.1.1.5. Procedures for exercising Enrollee's rights to Appeal;

2.15.1.1.6. Circumstances under which expedited resolution is available and how to request it; and

2.15.1.1.7. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the plan level Appeal.

2.15.1.2. Contractor must provide a member notice of resolution, as expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) calendar days from the day Contractor receives the Appeal, or in the case of an expedited Appeal within seventy-two (72) hours as described in section 2.15.3.5. An Enrollee notice, at a minimum, must include the result and date of the Appeal resolution. For decisions not wholly in the Enrollee's favor, Contractor, at a minimum must include:

2.15.1.2.1. Enrollee's right to request a State Fair Hearing;

2.15.1.2.2. How to request a State Fair Hearing;

2.15.1.2.3. Right to continue to receive benefits pending a State Fair Hearing;

2.15.1.2.4. How to request the continuation of benefits;

2.15.1.2.5. That Enrollee may be liable for cost of any continued benefits if the Contractor's action is upheld on Appeal;

2.15.1.2.6. Enrollee's right to file an external Grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC with respect to any and all disputes concerning Medi-Cal based services that are medical in nature and that relate to health care service plan obligations set forth under the Knox-Keene Act and the regulations promulgated thereunder.; and

2.15.1.2.7. How to file an external Grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC.

2.15.1.2.8. COHS plans that have not obtained a Knox-Keene license are not required to comply with 2.15.1.2.6 and 2.15.1.2.7 of this Contract.

2.15.1.3. Contractors without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must provide the Enrollee with written notice within two (2) calendar days of the reason for the extension and inform the Enrollee of the right to file a Grievance if they disagree with the delay; and the Contractor must make reasonable efforts to provide prompt oral notice of the delay. Effective January 1, 2020, Contractors with a Knox-Keene license may not allow extensions to resolve Appeals.

2.15.1.4. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Contractor must inform Enrollees that information is available in alternative formats and how to access those formats.

2.15.2. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services

shall proceed pursuant to the laws and regulations governing Medicare Appeals.

2.15.2.1. Written notice must be translated for Enrollees who speak Threshold Languages.

2.15.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.15.2.3. The Contractor must maintain written records of all Appeals activities. The Appeal record must include the name of the covered person for whom the Appeal was filed; the name of the Contractor's representative recording the Appeal; a general description of the reason for the Appeal; the date received; the date of each review or, if applicable, review meeting; and resolution information for each level of Appeal including date of resolution. The Appeal record must be accessible to CMS and DHCS upon request.

2.15.3. Medi-Cal Appeals and beneficiary protections will be maintained for Appeals regarding Medi-Cal services.

2.15.3.1. Enrollee or provider may file an Appeal with the Contractor either orally or in writing. The Contractor shall assist the Enrollee in confirming an oral Appeal in writing.

2.15.3.2. Enrollee, the Enrollee's authorized representative, or a Provider with the Enrollee's written consent, may file the oral or written Enrollee Appeal with the Contractor within sixty (60) calendar days after date of the Integrated Notice of Action.

2.15.3.3. Contractor must:

2.15.3.3.1. Timely acknowledge receipt of each Enrollee Appeal, including provide a written acknowledgemnent to the Enrollee within 5 calendar days of receipt.

2.15.3.3.2. Ensure that oral inquiries seeking to Appeal an action are treated as Appeals and confirm those

inquiries in writing unless the Enrollee or provider requests expedited resolution.

2.15.3.3.3. Provide a reasonable opportunity to present evidence and allegation of fact or law, in person, as well as in writing.

2.15.3.3.4. Provide the Enrollee and representative the Enrollee's case file, including medical records, and any other documents and records free of charge. The Enrollee's case file must be provided sufficiently in advance of the resolution timeframes.

2.15.3.3.5. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.

2.15.3.3.6. In compliance with 42 C.F.R. § 438.406(b), ensure that decision makers on Appeals were not involved in previous levels of review or decision-making nor a subordinate of any such individual and are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.15.3.3.6.1. A denial of an Appeal based on lack of medical necessity;

2.15.3.3.6.2. A Grievance regarding denial of expedited resolution of an Appeal; or

2.15.3.3.6.3. Any Appeal involving clinical issues.

2.15.3.4. Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and State laws and regulations, including but not limited to the following:

2.15.3.4.1. Federal Medicaid regulations governing Medi-Cal Managed Care Appeals and Medi-Cal Appeals in general, at 42 C.F.R. 431 Subpart E and 42 C.F.R. 438 Subpart F.

2.15.3.4.2. Standards for expedited review of Grievances involving an imminent and serious threat to the health of the Enrollee: Title 28, CCR, Sections 1300.68 and 1300.68.01;

2.15.3.4.3. Internal Contractor Appeal processes, in accordance with the Knox-Keene Act and the regulations promulgated thereunder, and external Appeal processes in accordance with DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code Section 1374.30) and the regulations promulgated thereunder; and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, Sections 51014.1, 51014.2, 53894, and 53858, as well as 42 C.F.R. § 431.244 related to standard and expedited fair hearings decisions;

2.15.3.4.4. Twelve (12) month continuity of care under certain circumstances. WIC section14182.17 (d)(7)(A)(ii).

2.15.3.5. Expedited internal Medi-Cal Appeals**.** Contractor shall comply with all State law and regulations pertaining to expedited Appeals, as well as the following requirements:

2.15.3.5.1. Contractor shall implement and maintain procedures as described below to resolve expedited internal Appeals for Medi-Cal services. These procedures shall be followed whenever Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.

2.15.3.5.2. Enrollee or provider may file an expedited Appeal either orally or in writing, and no additional Enrollee follow-up is required.

2.15.3.5.3. Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing.

2.15.3.5.4. Contractor must provide an Enrollee notice as quickly as the Enrollee's health condition requires, not exceeding 72 hours from the Contractor's receipt of the Appeal.

2.15.3.5.5. Contractor without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must make reasonable efforts to provide the Enrollee prompt oral notice, and provide the Enrollee with written notice of the reason for the extension within 2 calendar days and inform the Enrollee of the right to file a Grievance if they disagree with the delay. Contractor must issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. Effective January 1, 2020, Contractors with a Knox-Keene license may not allow extensions to resolve Appeals.

2.15.3.5.6. Contractor must provide written notice and must make a reasonable effort to provide oral notice of expedited Appeal decision.

2.15.3.5.7. Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

2.15.3.5.8. If Contractor denies a request for expedited resolution of an Appeal, it must:

2.15.3.5.8.1. Transfer the Appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the Contractor receives the Appeal with a possible fourteen (14) day extension for Contractactors without a Knox-Keene licsense, and

2.15.3.5.8.2. Give the Enrollee prompt oral notice of the denial of a request for expedited resolution and a written notice within two (2) calendar days.

2.15.3.6. Responsibilities in State Fair Hearings Related to Medi-Cal Benefits and Services**.** Contractor shall comply with all regulations and procedures regarding State Fair Hearings, set forth in the Manual of Policies and Procedures issued by the California Department of Social Services, pursuant to Title 22, CCR, Section 50953. Contractor shall have the following responsibilities with respect to State Fair Hearings that are expedited, in compliance with CDSS All County Letter 13-40.

2.15.3.6.1. An Enrollee, or an Enrollee's authorized representative, may request a State Fair Hearing either orally or in writing, consistent with 42 C.F.R. § 431.221.

2.15.3.7. Parties to an internal Medi-Cal Appeal or State Fair Hearing.

2.15.3.7.1. The parties to an internal plan Appeal or the State Fair Hearing related to a Medi-Cal benefit or service include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

2.15.3.8. Responsibilities in Independent Medical Reviews (IMR) Related to Medi-Cal Benefits and Services. Contractor, except for non-Knox Keene Act licensed COHS plans, shall comply with all statutes, regulations and procedures regarding DMHC's Independent Medical Review System, as set forth in the Knox-Keene Act and the regulations promulgated thereunder, including but not limited to the following requirements:

2.15.3.8.1. Enrollees may request an IMR regarding Medi-Cal services from DMHC within six (6) months of a denial, modification or delay of a Medi-Cal service based on Contractor's determination, in whole or in part, that the service is not medically necessary. Health & Safety Code Section 1374.30.

2.15.3.8.2. Enrollees shall not be required to participate in Contractor's internal Appeal process for more than thirty (30) days before applying for an IMR. Health & Safety Code Section 1368(b)(1)(A).

2.15.3.8.3. Enrollees whose Appeal requires expedited review pursuant to Health & Safety Code Section 1368.01 shall not be required to participate in the Contractor's Internal Grievance process for more than three (3) days before applying for an IMR. Health & Safety Code Section 1374.30(j)(3).

2.15.3.8.4. Enrollees may apply for an IMR without first participating in Contractor's Internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Enrollee's request for an experimental treatment was denied. Health & Safety Code Section 1368.03 and 1374.31(a); Title 28, CCR Section 1300.70.4(b)(2).

2.15.3.8.5. Contractor must notify Enrollee in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage. Title 28, CCR Section 1300.70.4(b); Health & Safety Code Section 1370.4(c)(1).

2.15.3.8.6. Enrollees may not request an IMR if a State Fair Hearing has already been held on the issue. Title 28, CCR Section 1300.74.30(f)(3).

2.15.3.8.7. If DMHC determines that Enrollee is not eligible for an IMR, the Enrollee's case will be reviewed through DMHC's consumer complaint process. Health & Safety Code Section 1368(b).

2.15.4. Medicare Appeals rights and protections will be maintained and enhanced for Medicare services only.

2.15.4.1. Federal Regulations and law will continue to govern all Medicare Appeals regarding Medicare services. As outlined in the MOU, Enrollees will continue to have access to the existing Medicare Part C and Part D Appeals processes. The

Medicare Part C process is set forth at 42 C.F.R. Part 422, Subpart M and in Chapter 13 of the Medicare Managed Care Manual. The Medicare Part D process is set forth at 42 C.F.R. Part 423, Subparts M and U and in Chapter 18 of the Medicare Prescription Drug Benefit Manual.

2.15.4.2. Hospital Discharge and other Discharge Appeals

2.15.4.2.1. The Contractor must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.15.4.2.2. The Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, SNF, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.15.5. Continuation of Benefits Pending an Appeal

2.15.5.1. Medicare Benefits and Services

2.15.5.1.1. The Contractor must continue providing benefits for all prior approved non-Part D Medicare benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending an internal Appeal.

2.15.5.1.2. Payments will not be recouped based on the outcome of the Appeal for services covered during all pending Appeals.

2.15.5.2. Medi-Cal Benefits and Services

2.15.5.2.1. The Contractor must continue providing all prior approved Medi-Cal benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first. This means that such benefits will continue to be provided to

Enrollees and that the Contractor must continue to pay providers for providing such services or benefits until the completion of the hearing process, or until the Enrollee withdraws the Appeal request or fails to file timely per the timeframes in 42 C.F.R. § 438.420, whichever comes first.

2.15.5.2.2. Payments will not be recouped based on the outcome of the Appeal for services covered during all pending Appeals.

2.15.6. In the event that the Enrollee pursues the Appeal in multiple forums (for example, if the Enrollee files for a State Fair Hearing while the IRE decision is pending) and receives conflicting decisions, the Contractor is bound by, and must act in accordance with, the decision favorable to the Enrollee or the decision closest to the Enrollee's relief requested on Appeal.

2.16. Quality Improvement Program

2.16.1. Quality Improvement (QI) Program. The Contractor shall:

2.16.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.16.1.1.1. Quality of physical health care, including primary and specialty care;

2.16.1.1.2. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation;

2.16.1.1.3. Quality of LTSS;

2.16.1.1.4. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services;

2.16.1.1.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.16.1.1.6. Enrollee experience and access to high quality, coordinated and culturally competent clinical care

and services, inclusive of LTSS across the care continuum.

2.16.2. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.16.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.16.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.16.2.3. Feedback provided by Enrollees and providers in the design, planning, and implementation of its CQI activities;

2.16.2.4. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS;

2.16.2.5. Issues identified by the Contractor, DHCS and/or CMS; and

2.16.2.6. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

2.16.3. QI Program Structure

2.16.3.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.

2.16.3.2. The Contractor shall:

2.16.3.2.1. Establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.16.3.2.2. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.16.3.2.3. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

2.16.3.2.4. Establish internal processes to ensure that the quality management activities for primary, specialty, Behavioral Health services, and LTSS reflect utilization across the Provider Network and include all of the activities in this Section 2.16 of this Contract and, in addition, the following elements:

2.16.3.2.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.16.3.2.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to

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utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to DHCS;

2.16.3.2.4.3. A process to measure Provider Network and Enrollees, at least annually, regarding their satisfaction with the Contractor's plan. The Contractor shall submit a survey plan to DHCS for approval and shall submit the results of the survey to DHCS and CMS;

2.16.3.2.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to utilization management activities, using inter-rater reliability measures;

2.16.3.2.4.5. A process for including Enrollees and their families in quality management activities, as evidenced by participation in consumer advisory boards; and

2.16.3.2.4.6. In collaboration with and as further directed by DHCS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.

2.16.3.2.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall include the following:

2.16.3.2.5.1. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

2.16.3.2.5.2. Organizational chart showing the key staff and the committees and bodies

responsible for quality improvement activities including reporting relationships of QI committee(s) and staff within the Contractor's organization.

2.16.3.2.5.3. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

2.16.3.2.5.4. The role, structure, and function of the Quality Improvement Committee.

2.16.3.2.5.5. The processes and procedures designed to ensure that all Covered Services that are Medically Necessary are available and accessible to all Enrollees regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services that are Medically Necessary are provided in a culturally and linguistically appropriate manner.

2.16.3.2.5.6. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Enrollees are able to obtain appointments within established standards.

2.16.3.2.5.7. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

2.16.3.2.5.8. Description of the activities, including activities used by persons with chronic

conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

2.16.3.2.5.9. A description of the mechanisms used to provide feedback to staff and providers regarding QI outcomes.

2.16.3.2.6. Address all aspects of health care, including specific reference to Behavioral Health services and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral Health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description as follows:

2.16.3.2.6.1. Address the roles of the designated physician(s), Behavioral Health clinician(s), and LTSS providers with respect to QI program;

2.16.3.2.6.2. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.16.3.2.6.3. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and utilization management.

2.16.3.2.7. Plans in Los Angeles and Orange counties must initiate QI activities for Enrollees in Medicare LTI status per Section 4.2.2.2.6.4.

2.16.3.2.7.1. QI activities under this initiative are subject to CMT approval.

2.16.3.3. Delegation of Quality Improvement Activities

2.16.3.3.1. Contractor is accountable for all QI functions and responsibilities (e.g. utilization management, credentialing and site review) that are delegated to First Tier, Downstream, and Related Entities.

2.16.3.3.2. Contractor shall maintain a system to ensure accountability for delegated QI activities, that at a minimum:

2.16.3.3.2.1. Evaluates First Tier, Downstream and Related Entity's ability to perform the delegated activities including an initial review to assure that the First Tier, Downstream, and Related Entity has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;

2.16.3.3.2.2. Ensures First Tier, Downstream, and Related Entity meets standards set forth by the Contractor and DHCS; and

2.16.3.3.2.3. Includes the continuous monitoring, evaluation and approval of the delegated functions.

2.16.3.3.3. Submit to DHCS and CMS an annual QI Work Plan that shall include the following components or other components as directed by DHCS and CMS:

2.16.3.3.3.1. Planned clinical and non-clinical initiatives;

2.16.3.3.3.2. The objectives for planned clinical and non-clinical initiatives;

2.16.3.3.3.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.16.3.3.3.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.16.3.3.3.5. Any issues identified by the Contractor, DHCS, Enrollees, and providers, and how those issues are tracked and resolved over time;

2.16.3.3.3.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.16.3.3.3.7. Process for correcting deficiencies.

2.16.3.3.4. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to DHCS and CMS. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and Behavioral Health services rendered, the effectiveness of LTSS, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and

2.16.3.3.5. Contractor shall develop a QI report for submission to DHCS and CMS on an annual basis. The annual report shall include:

2.16.3.3.5.1. An Assessment of the QI activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QI program, including but not limited to:

2.16.3.3.5.1.1. The collection of aggregate data on utilization;

2.16.3.3.5.1.2. The review of quality of services rendered; and

2.16.3.3.5.1.3. Outcomes/findings from Quality Improvement Projects (QIPs),

consumer satisfaction surveys and collaborative initiatives.

2.16.3.3.5.2. Consistent with 42 C.F.R. § 438.332(b), copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business, including accreditation status, any deficiencies noted, and expiration date of the accreditation. Include the corrective action plan developed to address noted deficiencies.

2.16.3.3.5.3. An assessment of First Tier, Downstream and Related Entity's performance of delegated QI activities.

2.16.3.3.6. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for quality management. QI staff shall include:

2.16.3.3.6.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated Behavioral Health provider, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program; and

2.16.3.3.6.2. A qualified individual to serve as the Cal MediConnect QI Director.

2.16.4. QI Activities

2.16.4.1. Performance Measurement

2.16.4.1.1. The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing

measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 422.516(a), 422.152, 423.514, 438.242(a) and (b), and 330.

2.16.4.1.2. Performance improvement projects must involve:

2.16.4.1.2.1. Measurement of performance using objective quality indicators

2.16.4.1.2.2. Implementation of systems interventions to achieve improvement in quality

2.16.4.1.2.3. Evaluation of the effectiveness of the interventions

2.16.4.1.2.4. Planning and initiation of activities for increasing and sustaining improvement

2.16.4.1.3. Measurement and improvement projects shall be conducted in accordance with requirements in the CFAM-MOU, Figure 7-1 core quality measures, and as specified in this Contract, and shall include, but are not limited to:

2.16.4.1.3.1. All HEDIS, HOS and CAHPS data, as well as all other measures specified in Figure 7-1 core quality measures of the MOU referenced above (Figure 7-1). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.16.4.1.3.2. The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by DHCS and CMS, as follows:

2.16.4.1.3.2.1. Collect and submit to DHCS, CMS and/or CMS' contractors, in a timely manner, data for the measures;

2.16.4.1.3.2.2. Contribute to all applicable DHCS and CMS data quality assurance processes, shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by DHCS and rectifying those inadequacies, as directed by DHCS

2.16.4.1.3.2.3. The Contractor shall demonstrate how to utilize results of the measures specified in any CMS and DHCS reporting requirements documents in designing QI initiatives.

2.16.4.2. Consumer Satisfaction Survey:

2.16.4.2.1. At intervals as determined by DHCS, DHCS' contracted EQRO will conduct a consumer satisfaction survey of a representative sample of Enrollees in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.

2.16.4.3. Quality Improvement Project (QIP)Requirements

2.16.4.3.1. The Contractor shall implement and adhere to all processes relating to the QIP requirements, as directed by DHCS and CMS, and as follows:

2.16.4.3.1.1. In accordance with 42 C.F.R. § 438.330 (b) and (d) collect information and data in accordance with QIP requirement specifications for its Enrollees; using the format and submission guidelines specified

by DHCS and CMS in annual guidance provided for the upcoming Contract year;

2.16.4.3.1.2. The Contractor is required to conduct or participate in two (2) QIPS approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in no more than two (2) QIPS for each Contract.

2.16.4.3.1.2.1. One (1) QIP must be an internal quality improvement project (IQIP), the requirements of which may be met by the completion of the Medicare QIP process.

2.16.4.3.1.2.2. One (1) QIP must be a DHCS facilitated statewide collaborative in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.16.4.4. Implement the QIP requirements, in a culturally competent manner;

2.16.4.5. Evaluate the effectiveness of QIP interventions, completed in a reasonable time period as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year;

2.16.4.6. Plan and initiate processes to sustain achievements and continue improvements;

2.16.4.7. Submit to DHCS and CMS, if requested by CMS or DHCS, comprehensive written reports, using the format, submission guidelines and frequency specified by DHCS and CMS. Such reports shall include information regarding progress on QIP requirements, barriers encountered and new knowledge gained. As directed by DHCS and CMS, the Contractor shall present this information to DHCS and CMS, if requested, at the end of the QI requirement project cycle as determined by DHCS and CMS; and

2.16.4.8. In accordance with 42 C.F.R. § 422.152 (c), develop a Chronic Care Improvement Program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the Contractor's plan population. Although the Contractor has the flexibility to choose the design of their CCIPs, DHCS and CMS may require them to address specific topic areas.

2.16.5. External Quality Review (EQR) Activities

2.16.5.1. The Contractor shall take all steps necessary to support the EQRO contracted by DHCS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. Contractor shall address the findings of the external review through its QI program. Contractor shall develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of Contractor's QI program. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in Contractor's QI program. DHCS may also require separate submission of an improvement plan specific to the findings of the EQRO. EQR activities shall include, but are not limited to the following:

2.16.5.1.1. Annual validation of performance measures reported to DHCS, as directed or calculated by DHCS;

2.16.5.1.2. Annual validation of QI projects required by DHCS and CMS; and

2.16.5.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, 42 C.F.R. Part 422, Subpart D, and 42 C.F.R. Part 423, Subpart D, and at the direction of DHCS, regarding access, structure and operations, and quality of care and services furnished to DHCS. The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.16.5.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum perform the following activities:

2.16.5.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.16.5.1.3.1.2. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, DHCS and CMS staff in a timely manner;

2.16.5.1.3.1.3. Serve as the liaison to the EQRO, QIO, DHCS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and DHCS in a timely manner; and

2.16.5.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or DHCS.

2.16.5.1.3.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The contractor shall maintain such documentation for a minimum of ten (10) years;

2.16.5.1.3.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or

2.16.5.1.4. Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and DHCS;

2.16.5.1.5. Implementing actions, as directed by DHCS and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, and CMS in subsequent years; and

2.16.5.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by DHCS and CMS.

2.16.6. CMS-Specified Performance Measurement and Performance Improvement Projects

2.16.6.1. The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.330.

2.16.7. Clinical Practice Guidelines

2.16.7.1. The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that are:

2.16.7.1.1. Based on valid and reliable clinical evidence or a consensus of health care professionals;

2.16.7.1.2. Consider the needs of Enrollees;

2.16.7.1.3. Developed in consultation with contracting health care professionals;

2.16.7.2. Contractor will review and update practice guidelines periodically as appropriate

2.16.7.3. Contractor will disseminate the practice guidelines to all affected providers and upon request, to Enrollees and potential Enrollees.

2.16.7.4. Delegated Credentialing: Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with:

2.16.7.4.1. Credentialing Provider Organization Certification: Contractor and their Network Providers (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the NCQA.

2.16.7.5. Contractor shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

2.16.7.6. Disciplinary Actions: Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider Appeal process.

2.16.7.7. Health Plan Accreditation: If Contractor has received a rating of "Excellent," Commendable" or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHCS requirements for credentialing and will be exempt from the DHCS medical review audit of credentialing.

2.16.7.8. Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

2.16.7.9. Credentialing of Other Non-Physician Medical Practitioners: Contractor shall develop and maintain policies and procedures that ensure that the credentials of nurse practitioners, certified nurse midwives, clinical nurse specialists and physician assistants have been verified in accordance with State requirements applicable to the provider category.

2.16.8. The Contractor's decisions regarding UM, Enrollee education, coverage of services, and other areas included in the practice guidelines must be consistent with the Contractor's clinical practice guidelines.

2.16.9. Quality Improvement Committee: Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that Enrollees and Network Providers, who are representative of the composition of the contracted Provider Network, actively participate on the committee or medical sub-committee that reports to the QIC.

2.16.9.1. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

2.16.9.2. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

2.17. Marketing, Outreach, and Enrollee Communications Standards

2.17.1. General Marketing, Outreach, and Enrollee Communications Requirements

2.17.1.1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 C.F.R. §§ 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, 423.2260, 438.10; and the Medicare Communications and Marketing Guidelines, with the following exceptions or modifications:

2.17.1.1.1. Contractor may complete an application for enrollment from a potential Cal MediConnect Enrollee and submit it to the State Enrollment Broker;

2.17.1.1.2. If approved to participate in Streamlined Enrollment, the Contractor may collect enrollment information from a potential eligible Enrollee and submit that request to the State per Section 2.3.1.7.

2.17.1.1.3. The Contractor may refer Enrollees and potential Enrollees who inquire about Capitated Financial

Alignment model eligibility or enrollment to the Enrollment Broker, although the Contractor may provide Enrollees and potential Enrollees with information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or enrollment to the Enrollment Broker;

2.17.1.1.4. The Contractor must make available to CMS and DHCS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or potential Enrollees;

2.17.1.1.5. The Contractor must convene all educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Enrollees or potential Enrollees, including persons with disabilities and persons using public transportation.

2.17.1.1.6. The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;

2.17.1.1.7. The Contractor does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and

2.17.1.1.8. The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:

2.17.1.1.8.1. The recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;

2.17.1.1.8.2. The Contractor is endorsed by CMS, Medicare, Medi-Cal, the federal government, DHCS, or similar entity.

2.17.2. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

2.17.2.1. Made available in alternative formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2.17.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments; and

2.17.2.3. Translated into Threshold Languages for all required vital materials, as specified in the Marketing Guidance for California Medicare-Medicaid Plans and annual guidance to Contractors on specific translation requirements for their Service Areas; and

2.17.2.4. Mailed with a multi-language insert or alternate language taglines that indicate that the Enrollee can access free interpreter services to answer questions about the plan. This message shall be written in the languages required in the Medicare Communications and Marketing Guidelines and Marketing Guidance for California Medicare-Medicaid Plans provisions on the multi-language insert and alternate language taglines.

2.17.2.5. Distributed to the Contractor's entire Service Area, as specified in Appendix I of this Contract.

2.17.3. Submission, Review, and Approval of Marketing, Outreach, and Enrollee Communications Materials

2.17.3.1. The Contractor must receive prior approval of all Marketing, Outreach, and Enrollee Communications in categories of materials that CMS and DHCS require to be prospectively reviewed. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §§ 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and DHCS. CMS and DHCS may agree to defer to one or the other party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties. Contractors must submit all materials that are consistent with the definition of communications materials and marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS

Marketing Module. The Contractor that is a non-Knox-Keene licensed COHS plan shall ensure that Marketing, Outreach, and Enrollee Communications involving Medi-Cal based services are consistent with the requirements of the Knox-Keene Act and the regulations promulgated thereunder. The Contractor, unless it is a non-Knox-Keene licensed COHS plan, shall submit to DMHC any Marketing, Outreach, and Enrollee Communications required to be reviewed by DMHC pursuant to the Knox-Keene Act.

2.17.3.2. CMS and DHCS may conduct additional types of review of Contractor's Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

2.17.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.17.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.17.3.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or DHCS determine it is appropriate to investigate.

2.17.3.2.4. "Secret shopper" activities where CMS or DHCS request Contractor materials, such as enrollment packets.

2.17.4. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.17.4.1. The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to Enrollees or potential new Enrollees more than ninety (90) days prior to the effective date of coverage for the following Contract year.

2.17.5. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.17.5.1. Consistent with the timelines specified in the Marketing Guidance for California Medicare-Medicaid Plans, the Contractor must provide new Enrollees with the following

materials which, with the exception of the materials specified in 2.17.5.4, must also be provided annually thereafter:

2.17.5.1.1. An Evidence of Coverage (EOC)/Member Handbook document, or a distinct and separate notice on how to access the Member Handbook online and how to request a hard copy, that is consistent with the requirements at 42 C.F.R. § 438.10, 42 C.F.R. § 422.111, and 42 C.F.R. § 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and DHCS.

2.17.5.1.1.1. Enrollee rights (see Appendix B);

2.17.5.1.1.2. An explanation of the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

2.17.5.1.1.3. How to request and obtain a copy of the Enrollee's medical records, and to request that they be amended or corrected;

2.17.5.1.1.4. How to obtain access to services, including specialty, Behavioral Health, pharmacy and LTSS providers;

2.17.5.1.1.5. How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.17.5.1.1.5.1. What constitutes Emergency Medical Condition, Emergency Services, and Post-Stabilization Care Services, with reference to the definitions in 42 C.F.R. § 438.114(a);

2.17.5.1.1.5.2. The fact that prior authorization is not required for Emergency Services;

2.17.5.1.1.5.3. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.17.5.1.1.5.4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract;

2.17.5.1.1.5.5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.17.5.1.1.5.6. The Post-Stabilization Care Services rules as outlined under 42 C.F.R. § 422.113(c).

2.17.5.1.2. Information about Advance Directives (at a minimum those required in 42 C.F.R. § 489.102 and 42 C.F.R. § 422.128), including Enrollee rights under the law of California; the Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience; that complaints concerning noncompliance with the Advance Directive requirements may be filed with DHCS; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and that information provided must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change;

2.17.5.1.3. How to obtain assistance from ESRs;

2.17.5.1.4. How to file Grievances and internal and external Appeals, including:

2.17.5.1.4.1. Grievance, Appeal and fair hearing procedures and timeframes;

2.17.5.1.4.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

2.17.5.1.4.3. A statement that when requested by the Enrollee, benefits will continue at the Contractor level for all benefits during the Contractor Appeal process, and the Enrollee may be required to pay to DHCS the cost of services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and, how the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

2.17.5.1.4.4. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as DHCS or CMS may identify, including an Ombudsperson;

2.17.5.1.5. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;

2.17.5.1.6. How and where to access any benefits that are available under the State plan but are not covered under the Contract, including any cost sharing, and how transportation is provided;

2.17.5.1.7. How to change providers;

2.17.5.1.8. How to disenroll from Cal Medi-Connect voluntarily;

2.17.5.1.9. How to receive counseling and referral services that are not covered under the Contract because of moral or religious objections;

2.17.5.1.10. The structure and operation of the Contractor; and

2.17.5.1.11. The structure and operation of any physician incentive plans the Contractor may have in place.

2.17.5.2. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and DHCS. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for Enrollees enrolled through Passive Enrollment.

2.17.5.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medi Cal, and Flexible Benefits and is consistent with the requirements in Section 2.17.5.10, or a distinct and separate notice on how to access this information online and how to request a hard copy.

2.17.5.4. A single identification (ID) card for accessing all Covered Services under the plan that uses the model document developed by CMS and DHCS.

2.17.5.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and DHCS's outpatient prescription drug benefit and that uses the model document developed by CMS and DHCS.

2.17.5.6. The procedures for an Enrollee to change Cal MediConnect Plans or to opt out of Cal MediConnect.

2.17.5.7. The Contractor must provide the following materials to current Enrollees on an ongoing basis:

2.17.5.7.1. An ANOC that summarizes all major changes to the Contractor's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and DHCS.

2.17.5.7.2. As needed to replace old versions or upon an Enrollee's request, a single ID card for accessing all Covered Services under the Contractor;

2.17.5.7.3. The Contractor must provide all Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.17.5.8. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the Contractor must provide Enrollees with at least thirty (30) calendar days advance notice regarding certain changes to the comprehensive, integrated formulary.

2.17.5.9. The Contractor must ensure that all information provided to Enrollees and potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.17.5.9.1. Made available in large print (at least 16 point font) to Enrollees as an alternative format, upon request;

2.17.5.9.2. For materials specified in the Medicare-Medicaid marketing guidance, available in Threshold Languages, as provided for in the Marketing Guidance for California Medicare-Medicaid Plans;

2.17.5.9.3. Written with cultural sensitivity and at a sixth grade reading level; and

2.17.5.9.4. Available in alternative formats, according to the needs of Enrollees and potential Enrollees, including Braille, oral interpretation services in non-English languages, as specified in Section 2.3.1.4 of this Contract; audiotape; ASL video clips, and other alternative media, as requested.

2.17.5.10. Provider/Pharmacy Network Directory

2.17.5.10.1. The Contractor must comply with the following maintenance and distribution requirements:

2.17.5.10.1.1. Maintain a combined Provider/Pharmacy Network directory

that uses the model document developed by CMS and DHCS;

2.17.5.10.1.2. Provide either a print copy or a distinct and separate notice about how to access this information online or request a hard copy, as specified in the Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans, to all new Enrollees at the time of enrollment and annually thereafter;

2.17.5.10.1.3. When there is a significant change to the network, the Contractor must send a special mailing to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual, immediately;

2.17.5.10.1.4. The Contractor must ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);

2.17.5.10.2. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy consistent with section 2.11.1.5 of this Contract to all Enrollees who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified; and

2.17.5.10.3. Include written and oral offers of such Provider/Pharmacy Network directory in its outreach and orientation sessions for new Enrollees.

2.17.5.11. Content of Provider/Pharmacy Network Directory. The Provider/Pharmacy Network directory must include, at a

minimum, the following information for all providers in the Contractor's Provider Network:

2.17.5.11.1. The names, addresses, and telephone numbers of all current Network Providers, and the total number of each type of provider, consistent with 42 C.F.R. § 422.111(h).

2.17.5.11.2. As applicable, Network Providers with training in and experience treating:

2.17.5.11.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2.17.5.11.2.2. Homeless persons;

2.17.5.11.2.3. Persons who are deaf or hard-of-hearing and blind or visually impaired;

2.17.5.11.2.4. Persons with co-occurring disorders; and

2.17.5.11.2.5. Other conditions.

2.17.5.11.3. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (Pacific Time) weekdays and on weekends;

2.17.5.11.4. As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;

2.17.5.11.5. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Provides, licensing information, such as license number or National Provider Identifier;

2.17.5.11.6. Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;

2.17.5.11.7. Whether the Network Provider is accepting new patients as of the date of publication of the directory;

2.17.5.11.8. Whether the Network Provider is on a public transportation route;

2.17.5.11.9. Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the provider's site;

2.17.5.11.10. As applicable, whether the Network Provider has access to language line interpreters;

2.17.5.11.11. For Behavioral Health Providers, training in and experience treating trauma, child welfare, and substance use;

2.17.5.11.12. A description of the roles of the PCP and ICT and the process by which Enrollees select and change PCPs.

2.17.5.12. The directory must include, at a minimum, the following information for all pharmacies in the Contractor's Pharmacy Network:

2.17.5.12.1. The names, addresses, and telephone numbers of all current Network Providers and pharmacies; and

2.17.5.12.2. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee services telephone line (as described in Section 2.12.2.1) for assistance in finding a convenient pharmacy.

2.18. Financial Requirements

2.18.1. Financial Viability

2.18.1.1. As specified in the DHCS Request for Solutions procurement, the Contractor must meet and maintain financial viability/standards compliance for each of the following elements:

2.18.1.1.1. Minimum Required Tangible Net Equity

2.18.1.1.1.1. Contractor at all times shall be in compliance with the Tangible Net Equity (TNE) requirements in accordance with 28 CCR 1300.76. If the Contractor does not meet TNE in a given period, the CMT shall have the power and authority to take one or more of the following sanctions against the Contractor for non-compliance:

2.18.1.1.1.1.1. Require the Contractor to submit a Corrective Action Plan within thirty (30) days of request by the CMT;

2.18.1.1.1.1.2. Appointment of temporary management if the Contractor has repeatedly failed to meet the contractual requirements or applicable federal and State law or regulation. The Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur; and

2.18.1.1.1.1.3. Take other appropriate action as determined necessary by DHCS.

2.18.1.1.2. Contractor must provide assurances satisfactory to the State showing that its provision against the risk of financial instability is adequate to ensure that its Enrollees will not be liable for the entity's

debts if the entity becomes insolvent. Contractor shall demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1.

2.18.2. Administrative costs

2.18.2.1. Contractor's administrative costs shall not exceed the guidelines established under 28 CCR section 1300.78.

2.18.2.2. Standards of Organization and Financial Soundness

2.18.2.2.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code Section 1375.1.

2.18.2.3. Working Capital Requirements

2.18.2.3.1. Contractor shall maintain a working capital and current ratio in accordance with 22 CCR 53864, which requires a TNE as defined in Title 28, Section 1300.76, or one of the following:

2.18.2.3.1.1. Current ratio of at least 1:1, or prior demonstration that the Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two (2) years, or evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current; or

2.18.2.3.1.2. Demonstration through its history of plan operations that the plan's arrangements for health care are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of

existing and proposed indebtedness, or enrollment growth.

2.18.2.3.2. The Contractor receiving Cal MediConnect enrollment, must demonstrate and maintain adequate working capital as required in California Health and Safety Code Section 1375.1, which requires consideration of:

2.18.2.3.2.1. The financial soundness of the Contractor's arrangements for Covered Services and the schedule of rates and charges used by the Contractor;

2.18.2.3.2.2. The adequacy of working capital; and

2.18.2.3.2.3. Arrangements with providers for the provision of Covered Services.

2.18.3. Financial Stability

2.18.3.1. Throughout the term of the Contract, the Contractor must:

2.18.3.1.1. Remain financially stable;

2.18.3.1.2. Maintain adequate protection against insolvency in an amount determined by the DMHC as described in Title 28, CCR, Section 1300.75.1.

2.18.3.1.3. Demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1 as follows:

2.18.3.1.3.1. Demonstrate through its history of operations and through projections, (which shall be supported by a statement as the facts and assumptions upon which they are based) that the Contractor's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness; and

2.18.3.1.3.2. Attest that the Contractor's arrangements for Covered Services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

2.18.3.1.4. Demonstrate that its working capital is adequate, including provisions for contingencies;

2.18.3.1.5. Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the Contract period for which payment has been made, the continuation of benefits to subscribers and Enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered; and

2.18.3.1.6. Obtain insurance or make other arrangements:

2.18.3.1.6.1. For the cost of providing to any Enrollee covered health care services the aggregate value of which exceeds $5,000 in any year;

2.18.3.1.6.2. For the cost of Covered Services provided to its Enrollees other than through the Contractor because medical necessity required their provision before they could be secured through the Contractor; and

2.18.3.1.6.3. For not more than ninety percent (90%) of the amount by which its costs for any of its fiscal years exceed one hundred fifteen percent (115%) of its income for such fiscal year.

2.18.4. Insolvency Reserve

2.18.4.1. The insolvency reserve shall have the same definition as minimum required TNE (see 2.18.1.1.1). The minimum TNE is defined by Title 28, CCR, Section 1300.76.

2.18.4.2. According to Title 28, CCR, Section 1300.76(e), California defines TNE as net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.

2.19. Data Submissions, Reporting Requirements, and Surveys

2.19.1. General Requirements for Data. The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

2.19.1.1. All information CMS and DHCS require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2.19.1.2. Any information CMS and DHCS require to comply with all applicable federal or State laws and regulations; and

2.19.1.3. Any information CMS or DHCS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals and enrollment/disenrollment rates.

2.19.2. General Reporting Requirements. The Contractor shall:

2.19.2.1. Submit to DHCS all applicable Medi-Cal reporting requirements in compliance with 42 C.F.R. § 438.602-606.

2.19.2.2. Submit to CMS applicable reporting requirements in compliance with 42 C.F.R. §§ 422.516, 423.514, 438.604, and 438.606.

2.19.2.3. Submit to CMS and DHCS all applicable MMP reporting requirements.

2.19.2.4. Submit to CMS and DHCS all required data in accordance with the specifications, templates and time frames described in this Contract.

2.19.2.5. Report HEDIS, as well as measures related to Long-Term Services and Supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medi-Cal measures required by DHCS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and DHCS.

2.19.2.6. Report rates for an under/over-utilization monitoring measure set based upon selected HEDIS use of service measures or any other standardized or DHCS-developed utilization measures selected by DHCS.

2.19.2.7. Submit additional reporting requirements as specified throughout this Contract, relevant regulation or law, or as provided through guidance.

2.19.2.8. Submit to CMS and DHCS all required reports and data in accordance with the specifications, templates, and time frames described in this Contract, unless otherwise directed or agreed to by CMS and DHCS.

2.19.2.9. Submit at the request of CMS or DHCS additional ad hoc or periodic reports or analyses of data related to the Contract.

2.19.2.10. Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by DHCS in accordance with applicable DPL(s) as indicated in Section 2.5.1.

2.19.2.11. Submit to DHCS Part D subcontractor conflict of interest letters on an annual basis. For Part D PDE data requests, securing and submitting appropriate letter from the First Tier, Downstream Entity to address potential conflicts of interests for First Tier, Downstream Entity users that may be affiliated with Part D Contractor sponsors. Letters should indicate either (a) no affiliation or, (b) if there is affiliation,

how the data will be kept separate and secure from Part D Contractor plan operations.

2.19.3. Management Information Systems Capability. The Contractor shall:

2.19.3.1. Maintain Information Systems that will enable the Contractor to meet all of DHCS's requirements as outlined in this Contract. The Contractor's Systems shall be able to support current DHCS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following DHCS standards:

2.19.3.1.1. The capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data completeness, timeliness, reasonability, and accuracy requirements of DHCS's Encounter Data submission. Contractor shall have and maintain a System that provides, at a minimum:

2.19.3.1.1.1. Eligibility data,

2.19.3.1.1.2. Information of Enrollees enrolled in Contractor's plan,

2.19.3.1.1.3. Provider claims status and payment data,

2.19.3.1.1.4. Health care services delivery Encounter Data,

2.19.3.1.1.5. Provider Network information, and

2.19.3.1.1.6. Financial information, as specified by DHCS.

2.19.3.2. Processes that support the interactions between financial, eligibility; provider; encounter claims; quality management/QI/utilization; and report generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.

2.19.3.3. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the Contractor and DHCS and any other entity deemed appropriate by DHCS. Such files shall

be transmitted to DHCS through secure FTP, HTS, or a similar secure data exchange as determined by DHCS;

2.19.3.4. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and providers to quickly and easily locate all relevant information. If directed by DHCS, establish appropriate links on the Contractor's website that direct users back to the DHCS website portal; and,

2.19.3.5. The Contractor shall cooperate with DHCS in its efforts to verify the accuracy of all Contractor data submissions to DHCS.

2.19.3.5.1. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

2.19.3.5.2. The Contractor shall demonstrate controls to maintain information integrity.

2.19.3.5.3. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DHCS.

2.19.4. Accepting and Processing Assessment Data

2.19.4.1. System Access Management and Information Accessibility Requirements

2.19.4.1.1. The Contractor shall make all systems and system information available to authorized CMS, DHCS and other agency staff as determined by CMS or DHCS to evaluate the quality and effectiveness of the Contractor's data and systems.

2.19.4.1.2. The Contractor is prohibited from sharing or publishing CMS or DHCS data and information without prior written consent from CMS or DHCS.

2.19.5. System Availability and Performance Requirements

2.19.5.1. The Contractor shall ensure that its Enrollee and provider web portal functions and phone-based functions are

available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.

2.19.5.2. The Contractor shall draft an alternative plan that describes access to Enrollee and provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to DHCS upon request. In the event of system failure or unavailability, the Contractor shall notify DHCS upon discovery and implement the COOP immediately.

2.19.5.3. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.20. Encounter Reporting

2.20.1. The Contractor must meet any diagnosis and encounter reporting requirements that are in place for Medicare Advantage plans and Medi-Cal managed care organizations. Furthermore, the Contractor's systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS and DHCS and updated from time to time. CMS and DHCS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

2.20.2. Encounter Data Submission

2.20.2.1. Contractor shall implement policies and procedures for ensuring the submission of complete, timely, reasonable, and accurate Encounter Data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements.

2.20.2.2. Contractor shall require First Tier, Downstream and Related Entities and non-contracting providers to provide claims and Encounter Data to Contractor, which allow Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure Encounter Data is complete, timely, reasonable, and accurate prior to submission to CMS.

2.20.2.3. Contractor shall submit complete, timely, reasonable, and accurate Encounter Data to CMS no less than monthly in the form and manner specified by DHCS and CMS. CMS will forward Encounter Data directly to the State.

2.20.2.4. Contractor shall submit Encounter Data that is at a minimum standard for completeness and accuracy as defined by CMS and DHCS. The Contractor must also correct and resubmit denied encounters as necessary.

2.20.2.5. A percentage of the monthly capitation payments will be withheld as described in Section 4.8.1.

3. CMS and DHCS Responsibilities

3.1. Contract Management

3.1.1. Administration. CMS and DHCS will:

3.1.1.1. Designate a CMT that will include at least one (1) contract officer from CMS and at least one (1) contract officer from DHCS authorized and empowered to represent CMS and DHCS about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representative and DHCS representatives will act as liaisons between the Contractor and CMS and DHCS for the duration of the Contract. The CMT will:

3.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.

3.1.1.1.2. Coordinate periodic audits and surveys of the Contractor;

3.1.1.1.3. Receive and respond to complaints;

3.1.1.1.4. Conduct regular meetings with the Contractor;

3.1.1.1.5. Coordinate requests for assistance from the Contractor and assign CMS and DHCS staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.1.1.6. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or DHCS;

3.1.1.1.7. Inform the Contractor of any discretionary action by CMS or DHCS under the provisions of the Contract;

3.1.1.1.8. Coordinate review of marketing materials and procedures;

3.1.1.1.9. Coordinate review of Grievance and Appeals data, procedures; and

3.1.1.1.10. Review, approve, and monitor the Contractor's outreach and orientation materials and procedures.

3.1.1.2. Review, approve, and monitor the Contractor's complaint and Appeals procedures;

3.1.1.3. Apply one or more of the sanctions provided in Section 5.3.13, including termination of the Contract in accordance with Section 5.5, if CMS and DHCS determine that the Contractor is in violation of any of the terms of the Contract stated herein;

3.1.1.4. Conduct site visits as determined necessary by CMS and DHCS to verify the accuracy of reported data; and

3.1.1.5. Coordinate the Contractor's external quality reviews conducted by the EQRO.

3.1.2. Performance Evaluation. CMS and DHCS will, at their discretion:

3.1.2.1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.18 and 2.19, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and DHCS will provide the Contractor with the written results of these evaluations;

3.1.2.2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

3.1.2.3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys.

3.2. Enrollment and Disenrollment Systems

3.2.1. CMS and DHCS will maintain systems to provide:

3.2.1.1. Enrollment and disenrollment information to the Contractor;

3.2.1.2. Continuous verification of eligibility status;

3.2.1.3. Identification of individuals determined as at risk or potentially at risk for abuse or overuse of specified prescription drugs per 42 C.F.R. §§ 432.100 and 423.153(f); and

3.2.1.4. For counties operating under COHS, DHCS will facilitate the Contractor in its responsibility for enrollment and disenrollment activities for Cal MediConnect.

3.2.2. Customer Service Team (CST) Enrollment Broker. DHCS or its designee shall assign a staff person(s) who shall have responsibility to:

3.2.2.1. Develop generic materials to assist potential Enrollees in choosing whether to enroll in Cal MediConnect. Said materials shall present the Cal MediConnect in an unbiased manner to potential Enrollees eligible to select a Cal MediConnect Plan. DHCS may collaborate with the Contractor in developing Cal MediConnect-specific materials;

3.2.2.2. Present the Cal MediConnect in an unbiased manner to potential Enrollees or those seeking to transfer from one Cal MediConnect to another. Such presentation(s) shall ensure that Enrollees are informed prior to enrollment of the following:

3.2.2.2.1. The rights and responsibilities of participation in Cal MediConnect;

3.2.2.2.2. The nature of the Contractor's care delivery system, including, but not limited to the Provider Network; and the HRA, and the ICT;

3.2.2.2.3. Orientation and other Enrollee services made available by the Contractor;

3.2.2.3. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.2.4. Be knowledgeable about the Contractor's policies, services, and procedures; and

3.2.2.5. At its discretion, develop and implement processes and standards to measure and improve the performance of the Enrollment Broker staff. The State shall monitor the activities of the Enrollment Broker.

4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments. CMS and DHCS will each contribute to the total capitation payment. CMS and DHCS will each make monthly payments to the Contractor for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive three (3) monthly payments for each Enrollee: one (1) amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Part A/B Component), one (1) amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from DHCS reflecting coverage of Medi-Cal services (Medi-Cal Component).

4.1.1.1. On a regular basis, CMS will provide DHCS with the Contractor-level payment information in the Medicare Plan Payment Report. The use of such information by DHCS will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the Contractor. On a regular basis, DHCS will also provide to CMS Contractor-level payment information including the Medicaid Capitation Payments.

4.1.2. Demonstration Year Dates. Capitation Rate updates will take place on January 1st of each calendar year for the Medicare components of the rates, with changes to savings percentages applicable on a Demonstration Year basis, as follows. Rate updates for the Medi-Cal component of the rates will take place at least once each calendar year. CMS and DHCS will provide the Contractor with a rate report at least annually to show applicable rates for the upcoming calendar year.

4.1.2.1. Demonstration Year Dates

Figure 4.1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017
4	January 1, 2018 – December 31, 2018
5	January 1, 2019 – December 31, 2019

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Demonstration Year	Calendar Dates
6	January 1, 2020 – December 31, 2020
7	January 1, 2021 – December 31, 2021
8	January 1, 2022 – December 31, 2022

4.2. Capitated Rate Structure

4.2.1. Underlying Rate Structure for the Medi-Cal Component

4.2.1.1. The Medi-Cal component will be paid as a single, blended rate that takes into account the relative risk of the population actually enrolled in the Contractor's Cal MediConnect Plan and is weighted accordingly.

4.2.1.1.1. For Demonstration Years 1-3, the population will be categorized into four risk adjustment population categories:

4.2.1.1.1.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.1.2. HCBS High: Enrollees identified as high utilizers of home and community-based services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.1.2.1. Enrollees who receive CBAS.

4.2.1.1.1.2.2. Enrollees who are clients of MSSP sites

4.2.1.1.1.2.3. Enrollees who receive IHSS and are classified under the IHSS program as "severely impaired" (SI).

4.2.1.1.1.3. HCBS Low: Enrollees identified as low utilizers of home and community-based services. These Enrollees are IHSS recipients and classified under the IHSS program as "not severely impaired."

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4.2.1.1.1.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

4.2.1.1.2. For Demonstration Years 4-8, the population will be categorized into four risk adjustment population categories:

4.2.1.1.2.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.2.2. CBAS and MSSP: Enrollees identified as utilizers of CBAS or MSSP services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.2.2.1. Enrollees who receive CBAS.

4.2.1.1.2.2.2. Enrollees who are clients of MSSP sites.

4.2.1.1.2.3. IHSS Only (no CBAS or MSSP): Enrollees identified as utilizers of IHSS services, who do not receive CBAS and are not clients of MSSP sites.

4.2.1.1.2.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

4.2.1.1.3. The State may, in consultation with CMS, modify the composition of the risk adjustment population categories upon its determination that such changes are appropriate. The State will inform the Contractor of any changes prior to modifying the risk adjustment population categories.

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4.2.1.2. The Medi-Cal component will utilize the risk adjustment methodology in the contracts that support the 1115(a) demonstration for the eligible population.

4.2.1.2.1. The Medi-Cal component will employ the population categories described above. Relative cost factors (RCF) will be established for each of the four (4) populations based on evaluation of the per member per month (PMPM) for each of the individual population groups, relative to the total Medi-Cal rate. As the total Medi-Cal rate incorporates incremental changes in population distribution (e.g. fewer Enrollees in institutional settings, increase in HCBS low for higher cost community well that may be more appropriately served by HCBS benefits), the calculation of the RCFs is also impacted by the assumed population distribution.

4.2.1.2.2. Contractor specific relative mix factors (RMF) will be computed through the use of RCFs and the proportion of each of the population category Enrollees in the plan. The RMFs will be computed by multiplying each Contractor's distribution of each of the population categories with the established RCFs to calculate a weighted average Contractor-specific RMF.

4.2.1.2.3. Contractor RMFs will be multiplied by the established Capitation Rate to determine the risk-adjusted Medi-Cal component payment rate.

4.2.1.3. The risk adjustment process will include three (3) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.

4.2.1.3.1. Phase I: The risk adjustment methodology will be applied monthly and retroactively to match actual enrollment into the Contractor's Cal MediConnect Plan. This phase will continue through each county's phase-in enrollment period for a minimum of one (1) year and will end at the start of the next fiscal quarter. For example, in a county with a 12-month phase-in that begins enrollment

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in April 2014, this phase would last through the end of March 2015. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, there will be no Phase I.

4.2.1.3.2. Phase II: This phase will be for one (1) fiscal quarter. The risk adjustment methodology will be prospectively applied at the start of the quarter. Weighting the risk categories will be based on the preceding month to the quarter enrollment snapshot, which will be available after the quarter ends and will be retroactively applied to that period. For example, in a county with a 12-month phase-in that begins enrollment in April 2014, this Phase II would be applicable for the fiscal quarter of April 2015 through June 2015. Enrollment data from March 2015 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, the county will immediately enter Phase II of the risk adjustment. The Phase II for San Mateo will be done according to a separate timeline, such that the risk adjustment methodology will be prospectively applied at the start of the Demonstration in April 2014 and again for a second quarter from July 2014 through September 2014 after which San Mateo will move into Phase III.

4.2.1.3.3. Phase III: Contractor rates will be based on a targeted relative mix of the population and will not be adjusted during the year. The first year of this phase will be the remaining period in the calendar year. Phase III for the county of San Mateo will begin with the fiscal year starting October 2014. The targeted relative mix of the population for the year would be based on enrollment in the plan leading up to the start of the phase III year and will include an assumed shift in population mix.

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4.2.1.3.3.1. Specific to Phase III, a targeted relative mix will be projected by the State and its actuaries. This mix will be designed to be achievable by the Contractor, based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement.

4.2.1.3.3.2. If the population mix for the Contractor for the year results in a greater than 2.5% impact to the Medicaid component of the rate paid as compared to the rate that would have been paid based on the actual mix, then the Contractor and Medicaid would share equally in any cost increases/decreases beyond the 2.5%. Actual plan gain or loss does not factor into this calculation.

4.2.1.4. With the structure as described above, DHCS and its actuaries will establish actuarially sound Capitation Rates for the contracts that support the 1115(a) demonstration program for beneficiaries in the target population for Cal MediConnect. These rates will be consistent with 42 C.F.R. § 438.4 and reviewed by the CMS Regional Office. The CMS approved rates will serve as the baseline Medicaid costs.

4.2.1.5. Upon request prior to and throughout the Demonstration, the State and its actuaries will provide to CMS the underlying data for the rate calculations associated with the contracts that support the 1115(a) demonstration.

4.2.1.6. Medicaid payment rates will be determined by applying annual savings percentages in Figure 4.2 to the applicable Capitation Rates for the contracts that support the 1115(a) demonstration.

4.2.1.7. As allowed under the rates for the contracts that support the 1115(a) demonstration, DHCS and its actuaries will calculate a range of actuarially sound capitation payment rates including lower bound and upper rates. The application of the savings percentage will apply to all rates, including any prospective or retroactive adjustments, within actuarially sound rate range.

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4.2.1.8. Consistent with the Medicare rate updates at 4.2.2.2.6, the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect in Los Angeles and Orange counties beginning in 2017 will be considered during Medicaid rate development for 2017 and subsequent years, as applicable.

4.2.2. Underlying Rate Structure for Medicare Components of the Capitation Rate.

4.2.2.1. Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.5. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare FFS standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the enrolled population enrolled in each program prior to the Demonstration. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant

fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3.5% bonus county rate (benchmark) for the applicable county as of January 2015 (for CY 2014 the baseline was the 3-star county rate).

4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.

4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.2.2.5. If an Enrollee elects to receive the Medicare hospice benefit, the Enrollee may remain in the Cal MediConnect Plan, but will obtain the hospice service through the Medicare FFS benefit and the Cal MediConnect Plan would no longer receive the Medicare Parts A/B component for that Enrollee as described in this section. Medicare hospice services and hospice drugs and all other original Medicare services would be paid for under Medicare FFS. Cal MediConnect Plans and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care. Cal MediConnect Plans would

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continue to receive the Medicare Part D component for all non-hospice covered drugs. Election of hospice services does not change the Medi-Cal component unless otherwise specified in the DHCS 1115(a) demonstration.

4.2.2.2.6. Beginning January 2017, CMS will make an outlier adjustment for the Medicare A/B payments for non-ESRD beneficiaries served by the Contractor in Los Angeles and Orange Counties.

4.2.2.2.6.1. This adjustment will reflect the historical ratio of actual Medicare A/B FFS costs for the long term institutional (LTI) population in this county/counties to the predicted costs for this population, based on the standardized FFS county rates and the HCC risk adjustment model. This payment adjustment will be made retroactively after the end of each demonstration year, beginning in CY 2017 and going forward.

4.2.2.2.6.2. The outlier adjustment is a multiplicative factor equal to 95% of [the historical ratio minus 1 (one)] times the predicted rate for a baseline period. Specifically, the adjustment would be equal to: (the outlier adjustment percentage of 95%) times (this historical ratio from 4.2.2.2.6.1 minus 1(one)) times (the standardized FFS county rate for the applicable calendar year for the applicable county) times (the average final HCC risk score for the applicable calendar year for the population that meets the criteria in 4.2.2.2.6.3) times (the number of member months for the applicable calendar year associated with the population that meets the criteria in 4.2.2.2.6.3).

4.2.2.2.6.3. This adjustment is limited to those new Cal MediConnect members who newly enroll in the CalMediConnect demonstration as of January 1, 2017, or later; were in Medicare LTI status at the time of their Cal

MediConnect enrollment; and were in Medicare FFS at the time of their Cal MediConnect enrollment.

4.2.2.2.6.4. Plans must initiate and report on corresponding quality improvement activities focused on Cal MediConnect members in Medicare LTI status per Section 2.16.3.2.7.

4.2.2.3. Medicare Part D

4.2.2.3.1. The Medicare Part D component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as well as CMS-estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

4.2.2.3.2. The monthly Medicare Part D component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.2.3. Aggregate Savings Percentages

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare A/B and Medi-Cal components of the capitated rate, provided that such savings percentages may be adjusted in accordance with Sections 4.2.3.2 herein.

4.2.3.2. Savings percentages will not be applied to the Part D Component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

Figure 4.2: Savings Percentages

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	Demonstration Year 1	Demonstration Year 2	Demonstration Years 3-8
Minimum Savings Percentages	**1.00%**	**2.00%**	**4.00%**
County Specific Interim Savings Percentages: the sum of the minimum savings percentages and the county-specific addition			
Los Angeles	+ 0.00%	+ 1.50%	+ 1.50%
Orange	+ 0.42%	+ 1.50%	+ 1.50%
Riverside	+ 0.22%	+ 1.50%	+ 1.14%
San Bernardino	+ 0.44%	+ 1.50%	+ 1.50%
San Diego	+ 0.23%	+ 1.50%	+ 1.10%
San Mateo	+ 0.47%	+ 0.33%	+ 0.00%
Santa Clara	+ 0.23%	+ 1.45%	+ 0.95%

4.2.3.3. Limited risk corridors will be applied as described in Sections 4.3 and 4.4 on a Contractor basis and be reconciled after application of any risk adjustment methodologies and any other adjustments, as described in Section 4.2.1.2.

4.2.3.3.1. Risk corridors will be reconciled as if the Contractor had received the full quality withhold payment.

4.2.3.3.2. The application of county-specific interim savings percentages in Section 4.2.3.1. establishes the initial Capitation Rates for purposes of the risk corridor calculation for Demonstration Years 1-3, as described in Section 4.3.

4.2.3.3.3. A limited one-sided risk corridor will apply for Demonstration Years 6-8, as described in Section 4.4.

4.3. Risk Corridors for Demonstration Years 1-3

4.3.1. General Provisions

4.3.1.1. Calculation of Gains and Losses: The risk-sharing arrangement described in this section of the Contract may result in payment by the State and CMS to the Contractor or by the Contractor to the State and CMS.

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4.3.1.1.1. All payments to be made by the State and CMS to the Contractor or by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.3.1.1.2. All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Adjusted Service Expenditures and Adjusted Non-Service Expenditures, as required in Section 4.3.3 All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.3.1.1.3. CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, or by CMS and the state to the Contractor, as described in Section 4.3.3.1.

4.3.1.2. Two-sided risk corridors will apply for Demonstration Years 1-3.

4.3.1.3. Allowable Expenditures

4.3.1.3.1. CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Section 4.3.3, and Section 2.17-2.19 of this Contract). CMS and the State reserve the right to audit Actual Service Expenditure and Actual Non-Service Expenditure data.

4.3.1.3.2. CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the State and the Contractor will confer and make a good

faith effort to reconcile those differences before the calculation of the final settlement.

4.3.1.3.3. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.3.1.3.4. The State and CMS reserve the right to adjust expenditures for services that are reimbursed at more than ten percent (10%) above the median reimbursement rate of all plans within a region. For the purposes of the risk corridor, the Regions are defined as the Northern Counties Region (San Mateo and Santa Clara Counties) and the Southern Counties Region (Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties).

4.3.1.3.5. The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.3.2. Risk Corridor Parameters

4.3.2.1. The Demonstration will utilize a limited down-side risk corridor and a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), intergovernmental transfers, and as if all Contractors had received the full quality withhold payment.

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4.3.2.1.1. Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.3.2.1.3.

4.3.2.1.2. Adjusted Interim Capitation Rate Revenue and Adjusted Final Capitation Rate Revenue: As described in Section 4.2.3.1, the application of county-specific interim savings percentages in Figure 4-2, with the adjustments described in Section 4.3.2.1.6, establishes the Adjusted Interim Capitation Rate Revenue. The Adjusted Final Capitation Rate Revenue is the revenue, with the adjustments described under Section 4.3.2.1.6, that the Contractor would have received if the minimum savings percentages, rather that the county-specific interim savings percentages, were applied.

4.3.2.1.3. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures, with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.3.2.1.4. Down-Side Risk Corridor Payment/Recoupment

4.3.2.1.4.1. Losses will be compared to Contractor's underwriting profit/risk/contingency load. If losses exceed this amount, the difference of the loss less the underwriting profit/risk/contingency load shall be eligible for payment under the risk corridor. No payment shall be made for losses that are less than the underwriting profit/risk/contingency load.

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4.3.2.1.4.2. First Band: For losses in excess of the underwriting profit/risk/contingency load, the State and CMS will make payment to the Contractor of sixty-seven percent (67%) of the loss, with the maximum CMS/State payment to the Contractor not exceeding the Adjusted Final Capitation Rate Revenue minus the Adjusted Interim Capitation Rate Revenue. The share of the payment made by the State and CMS will be as described in Section 4.3.2.1.1. All losses in excess of the CMS/State payment are the responsibility of the Contractor.

4.3.2.1.5. Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.3.2.1.5.1. First Band: The first band is equal to the difference between the Adjusted Interim Capitation Rate Revenue and the Adjusted Final Capitation Rate Revenue. For the purposes of the up-side risk corridor, for Contractors in counties where the interim saving percentage is equal to the minimum savings percentage, for the purposes of the up-side risk corridor, the Adjusted Interim Capitation Rate Revenue shall be further modified by applying savings percentages of one and a half percent (1.5%) in Demonstration Year 1, three and a half percent (3.5%) in Demonstration Year 2 and 5.5% in Demonstration Years 3, where applicable, rather than one percent (1.0%), two percent (2.0%) and four percent (4.0%), respectively; this is determined by multiplying the initial Adjusted Interim Capitation Rate Revenue by (1 – the applicable 1.5%, 3.5% or 5.5% savings percentages above) / (1- Interim Savings Percentage).

4.3.2.1.5.1.1. For the portion of gains in the first band, no payment will be made by

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the Contractor to the State and CMS.

4.3.2.1.5.2. Second Band: The second band is the same size as the first band. For the portion of gains in the second band, the Contractor will make payment to the State and CMS of fifty percent (50%) of this portion of the gain, with the share of the payment made to the State and CMS as described in Section 4.3.2.1.1.

4.3.2.1.5.3. Third Band: For the portion of gains greater than the upper limit of the second band, no payment will be made by the Contractor to the State and CMS.

Figure 4-3 Demonstration Years 1-3 Risk Sharing Corridor Table (for illustrative purposes only)

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Risk Corridor Band	Incremental Loss or Gain[1]	% Contractor Risk Sharing	% the State & CMS Risk Sharing	% CMS Risk Sharing	% the State Risk Sharing[2]
Loss Band 1	All Losses in Excess of Underwriting Profit/Risk/ Contingency Load	33%	67% (up to maximum not exceeding Adjusted Final Capitation Rate Revenue - Adjusted Interim Capitation Rate Revenue)	(67%) * (Medicare A/B Percent of Rate)	(67%)*(Medi-Cal Percent of Rate)
Gain Band 1	Gains ≤ (Adjusted Interim Capitation Rate Revenue – Adjusted Final Capitation Rate Revenue)[3]	100%	0%	0%	0%
Gain Band 2	Gains ≤ Band equal to size of *Gain Band 1*	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains > Upper Limit of *Gain Band 2*	100%	0%	0%	0%

[1] Loss and gain reflected on an incremental basis. Gains in Gain Bands 3 still results in risk sharing reconciliation for the gain in Gain Band 2.

[2] All State Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

[3] The Adjusted Interim Capitation Rate Revenue is modified for counties in which the Interim Savings Percentage equals the Minimum Savings Percentage.

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4.3.3. Risk Sharing Settlement: CMS and the State shall determine a final settlement of payments made by the Contractor to CMS and the State, or by CMS and the State to the Contractor under this section. If any significant determinant of revenues or costs remains outstanding such that the timelines in this section do not apply, CMS and the State will establish reasonable timeframes for reporting payment and related final settlement timeframes.

4.3.3.1. Final settlement: CMS and the State shall determine a final settlement based on fifteen (15) months of claims run-out and an IBNR estimate.

4.3.3.1.1. For the purpose of the final settlement, the Contractor will jointly provide to CMS and the State the following within four hundred eighty (480) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the State. A complete and accurate report of Actual Non-Service Expenditures for Enrollees in the applicable Demonstration Year;

4.3.3.1.2. A complete and accurate report of Actual Service Expenditures, based on category of services, for Enrollees based on claims incurred for the applicable Demonstration Year, including fifteen (15) months of claims run-out;

4.3.3.1.3. The Contractor's best estimate of any claims incurred but not reported for claims run-out beyond fifteen (15) months and any IBNR completion factors by category of service;

4.3.3.1.4. A complete and accurate report of Part D revenue and expenditure, as required under 42 C.F.R. § 423.514(a)(1) of this Contract;

4.3.3.1.5. A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Service Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments,

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adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care;

4.3.3.1.6. A complete and accurate report of net reinsurance costs that are included in the reported Actual Non-Service Expenditures;

4.3.3.1.7. Financial reports;

4.3.3.1.8. Encounter Data, as required under Section 2.19 of this Contract;

4.3.3.2. CMS and the State shall provide the Contractor with a final reconciliation under the risk corridor arrangement within five hundred ten (510) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the State. Any balance due between the Contractor and CMS and the State shall be paid within sixty (60) days of the Contractor receiving the final reconciliation from CMS and the State; and

4.3.3.3. The Contractor shall provide any additional information upon request from CMS and the State necessary to calculate Total Adjusted Expenditures.

4.4. One-sided risk corridors will be established for Demonstration Years 6-8

4.4.1. General Provisions

4.4.1.1. The Demonstration will utilize a one-sided risk corridor for Demonstration Years 6 through 8. The one-sided risk corridor is designed to limit the profits received by Cal MediConnect MMPs to a reasonable percentage of total revenue.

4.4.1.2. Calculation of Gains and Losses: The risk sharing arrangement described in this section of the Contract may result in payment by the Contractor to the State and CMS.

4.4.1.2.1. All payments made by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.4.1.2.2. All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Adjusted Non-Service Expenditures and Adjusted Service Expenditures, as required in Section 4.4.3. All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.4.1.2.3. CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, as described in Section 4.4.3.

4.4.1.3. Allowable Expenditures

4.4.1.3.1. CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Section 4.4.3 and Section 2.17-2.19 of this Contract). CMS and the State reserve the right to audit Actual Service Expenditure and Actual Non-Service Expenditure data.

4.4.1.3.2. CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the State and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State

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will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.4.1.3.3. The State and CMS reserve the right to adjust expenditures for services that are reimbursed significantly above the median reimbursement rate of other comparable plans. The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. The State and CMS will provide additional detail regarding the methodology for considering adjustments to expenditures in separate technical guidance. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.4.2. One-Sided Risk Corridor Parameters

4.4.2.1. The Demonstration will utilize a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), and intergovernmental transfers. The risk corridor will reflect the actual quality withhold payment received back by the Contractor.

4.4.2.1.1. Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.4.2.1.2.

4.4.2.1.2. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures,

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with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.4.2.1.3. Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.4.2.1.3.1. First Band: The Contractor will retain all of the gains that are equal to or less than five percent (5%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

4.4.2.1.3.2. Second Band: DHCS/CMS and the Contractor will share that portion of the gains that is over five percent (5%) and less than or equal to seven percent (7%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with seventy-five percent (75%) retained by the Contractor and twenty percent (25%) paid to DHCS/CMS.

4.4.2.1.3.3. Third Band: DHCS/CMS and the Contractor will share that portion of the gains that is over seven percent (7%) and less than or equal to nine percent (9%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with fifty percent (50%) retained by the Contractor and fifty percent (50%) paid to DHCS/CMS.

4.4.2.1.3.4. Fourth Band: DHCS/CMS and the Contractor will share that portion of the gains that is over nine percent (9%) and less than or equal to twelve percent (12%) of the

Adjusted Interim Capitation Rate revenue received by the Contractor, with twenty-five percent (25%) retained by the Contractor and seventy-five percent (875%) paid to DHCS/CMS.

4.4.2.1.3.5. Fifth Band: DHCS/CMS will recoup the entire portion of the gains that exceeds twelve percent (12%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

Figure 4-4 Demonstration Years 6-8 Risk Sharing Corridor Table (for illustrative purposes only)

Risk Corridor Band	**Incremental Gain[1]**	**% Contractor Gain Sharing**	**% State & CMS Gain Sharing**	**% CMS Gain Sharing**	**% State Gain Sharing**
Gain Band 1	Gains ≤ 5%	100%	0%	0%	0%
Gain Band 2	Gains >5% and ≤7%	75%	25%	(25%) * (Medicare A/B Percent of Rate)	(25%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains >7% and ≤9%	50%	50%	(75%) * (Medicare A/B Percent of Rate)	(75%)*(Medi-Cal Percent of Rate)
Gain Band 4	Gains >9% and ≤12%	25%	75%	(75%) * (Medicare A/B Percent of Rate)	(75%)*(Medi-Cal Percent of Rate)
Gain Band 5	Gains >12%	0%	100%	(100%) * (Medicare A/B Percent of Rate)	(100%)*(Medi-Cal Percent of Rate)

[1] Gain reflected on an incremental basis. Gains in Gain Band 5 still results in risk sharing reconciliation for the gain in Gain Bands 2-4.

4.4.3. Risk Sharing Settlement

4.4.3.1. CMS and the State shall determine final settlement of payments made by the Contractor to CMS and the State.

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4.4.3.2. Data Submission. The Contractor shall submit to DHCS and CMS, in the form and manner prescribed by DHCS and CMS, the necessary data to calculate and verify the final settlement after the end of each applicable Demonstration Year.

4.4.3.3. In the event the Contractor qualifies to make both a risk corridor payment to CMS and DHCS, as well as an MLR remittance as described in Section 4.12.1, the risk corridor calculation will be net of an MLR remittances.

4.5. Medicare Risk Adjustment Methodology

4.5.1. Medicare Parts A/B: The Medicare A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for Cal MediConnect.

4.5.2. Coding Intensity Adjustment Factor

4.5.2.1. CMS will calculate calendar year 2014 rates as if the coding intensity adjustment factor were not applied, to reflect the fact that virtually all Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. Operationally CMS will still apply the coding intensity adjustment factor to the risk scores but will increase the Medicare A/B baseline for non-ESRD beneficiaries and beneficiaries with an ESRD status of functioning graft, to offset this.

4.5.2.2. In calendar year 2015, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees except as indicated in Section 4.5.2.4. This will apply the prevailing Medicare Advantage coding intensity adjustment, on a county-specific basis, proportional to the anticipated proportion of Cal MediConnect Enrollees in 2015 with Medicare Advantage or Cal MediConnect experience in 2014, prior to September 30, 2014.

4.5.2.3. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Cal MediConnect Enrollees, with the exception of Cal MediConnect Enrollees in Orange County given the start date of enrollment in this county.

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4.5.2.3.1. For Orange County in CY 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Orange County Cal MediConnect Enrollees in 2016 with Medicare Advantage or demonstration experience prior to September 30, 2015. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to Cal MediConnect Enrollees in Orange County.

4.5.2.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts will not be risk adjusted.

4.5.3. Medi-Cal Component: For the Medi-Cal Component of the capitated rate, DHCS will rely on the methodology described in Section 4.2.1.3 to account for differences in risk among the eligible population.

4.6. Payment Terms

4.6.1. CMS and DHCS will each make monthly, prospective capitation payments to the Contractor, with retroactive adjustments, as applicable, as described in Sections 4.2.2.2.6, 4.2.2.3.1, 4.7 and 4.14.

4.6.1.1. The Medicare Parts A/B component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts. The payment period will commence on the Contract Operational Start Date.

4.6.1.2. DHCS shall remit to the Contractor a capitation payment each month for each Enrollee that appears on the approved

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list of Enrollees supplied to Contractor by DHCS. The Capitation Rate shall be the amount specified in Section 4.2.1.6. The payment period for health care services shall commence on the Contract Operational Start Date.

4.6.1.2.1. DHCS will pay an IHSS interim payment on behalf of the Contractor for IHSS Provider payroll as a portion of the covered Medicaid services. The IHSS interim payment will be reconciled as described in Section 4.14.3.1. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.7. Modifications to Capitation Rates. CMS and DHCS will jointly notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in Section 4.15.

4.7.1. Rates will be updated using a similar process for each calendar year. Subject to Section 4.7.2., changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage and Part D rate announcements will be made only if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate, and attainable payment rates for Cal MediConnect. Such changes may be based on the following factors: shifts in enrollment assumptions; changes due to litigation; changes or discrepancies in federal law and/or State policy compared to assumptions about federal law and/or State law or policy used in the development of baseline estimates; changes in coding intensity; and other factors as determined appropriate and approved by CMS and the State.

4.7.2. For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.

4.7.3. Subject to Section 4.7.2, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and DHCS to have a material change in baseline estimates for any given payment year, baseline estimates and

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corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.7.4. Changes to the savings percentages will be made if and when CMS and DHCS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines or if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate and attainable payment rates for Cal MediConnect.

4.7.5. IHSS wage adjustments may occur during Cal MediConnect. Changes to the Medi-Cal Component will be made annually by county and may be retroactively applied to account for IHSS wage adjustments that occurred during the calendar year, subject to CMS review. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.8. Quality Withhold Policy for Medi-Cal and Medicare A/B Components of the Integrated, Risk-Adjusted Rate

4.8.1. Under Cal MediConnect, both payers will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D component amounts. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.

4.8.1.1. In Demonstration Year 1 of Cal MediConnect, the withhold will be 1% of the respective components of the Capitation Rate. **See Figure 4.5**.

4.8.1.2. For Demonstration Year 1, which crosses calendar years, the Contractor will be evaluated to determine whether it has met quality withhold requirements at the end of CY 2014 and at the end of CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Figure 4.5: Quality Withhold Measures for Demonstration Year 1

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Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Assessments	CMS defined process measure	X	
Consumer Governance Board	CMS defined process measure	X	
Getting Appointments and Care Quickly	AHRQ/CAHPS	X	
Customer Service	AHRQ/CAHPS	X	
Behavioral Health Shared Accountability Policies and Procedures	State defined process measure		X
Documentation of Care Goals	State defined process measure		X
Ensuring Physical Access to Buildings, Services and Equipment	State defined process measure		X
Interaction with Care Team	State defined process measure		X

4.8.1.3. The quality withhold will increase to two percent (2%) in Demonstration Year 2, three percent (3%) for Demonstration Years 3-5 and four percent (4%) for Demonstration Years 6-8. **See Figure 4.6.**

4.8.1.4. Payment will be based on performance on the quality withhold measures listed in Figure 4.6 below. The Contractor must report these measures according to the prevailing technical specifications for the applicable measurement year.

4.8.1.5. If the Contractor is unable to report at least three (3) of the quality withhold measures listed in Figure 4.6 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Figure 4.6: Quality Withhold Measures for Demonstration Years 2 -8

Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Encounter Data	CMS defined process measure	X	
Plan All-Cause Readmissions	NCQA/HEDIS	X	

	Source	CMS Core Withhold Measure	California Withhold Measure
Annual Flu Vaccine	AHRQ/CAHPS	X	
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	X	
Reducing the Risk of Falling	NCQA/HEDIS/HOS	X	
Controlling Blood Pressure	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	CMS/PDE Data	X	
Behavioral Health Shared Accountability Process Measure (DY 3 Only)	State-defined process measure		X
Behavioral Health Shared Accountability Outcome Measure	State-defined measure		X
Documentation of Care Goals	State defined process measure		X
Interaction with Care Team	State defined process measure		X

4.8.2. CMS and DHCS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.8.3. Whether or not the Contractor has met the quality requirements in a given year will be made public, as will relevant quality results in all Demonstration Years.

4.9. Shared Financial Accountability Strategy for Incentive Payments for Behavioral Health Services

4.9.1.1. Shared accountability between the Cal MediConnect Plan and county Behavioral Health agencies aims to promote Care Coordination to ensure Enrollees have access to all needed services. Shared accountability builds on the performance-based quality withhold from the plans' Capitation Rates of one percent, two percent, three percent, and four percent (1%, 2%, 3%, and 4%) in years one, two, three through five, and six through eight of the Demonstration. By meeting specified quality measures, the Contractor can earn back the withheld capitation revenue by meeting specified quality objectives. Under this shared accountability strategy, one (1) withhold measure in year

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one, one (1) withhold measure in year two, two (2) withhold measures in year three, and one (1) withhold measure in years four through eight will be tied to Behavioral Health coordination with the county.

4.9.1.2. The Contractor will be required to share with the applicable county Behavioral Health agencies a minimum amount of funds earned back through the shared accountability quality withhold measure each year. Contractor may choose to go above and beyond this minimum. This must be executed as directed in future guidance from DHCS.

4.9.1.3. The Contractor must provide an incentive payment each year to the county Behavioral Health agency that is equal to or greater than the value of each quality withhold measure multiplied by the proportion of Enrollees identified as having Behavioral Health needs and who are receiving county services. The proportion is defined as follows:

4.9.1.3.1. The denominator will be the total number of Enrollees with mental illness or substance use disorders, as defined for the emergency department reduction quality withhold measure for Years 2 through 8. The numerator would be the subset of those Enrollees who are receiving services through the county Behavioral Health agency.

4.9.1.3.2. In all counties except Los Angeles, the mental health and substance use departments are administratively combined. In Los Angeles County, the proportion of Enrollees with substance use disorders receiving county drug and alcohol services would be calculated separately from the Enrollees with mental illness population to identify the incentive payment amount paid to the Department of Public Health.

4.9.1.3.3. Assuming successful completion and equal weighting of each measure, total Behavioral Health shared accountability incentive payments in each year would equal:

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- Year 1 Measure A = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 1 Measure B = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 2: ED Measure = 0.002 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 3-8: ED Measure = 0.003 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.

4.10. Medicare A/B Disenrollment Penalty

4.10.1. Beginning in Demonstration Year 5 (CY 2019) CMS will implement a retrospective financial penalty in the Medicare A/B component of the Capitation Rate for Contractors with high disenrollment rates. This penalty is intended to address selection bias that may be impacting Medicare costs for the Cal MediConnect Demonstration and to align incentives for Contractors to improve quality for all Enrollees.

4.10.2. Performance will be evaluated annually using the existing Medicare Part C measure entitled "Members Choosing to Leave Plan." For DYs 5 and 6, CMS intends to maintain the benchmark at the median Contractor performance from measurement year 2017. For DYs 7 and 8, CMS will set the benchmark at the median Contractor performance from the most recent measurement year. Contractors with rates above the benchmark will be subject to the penalty on a sliding scale, starting at one percent (1%) and up to two percent (2%). Additional detail regarding the methodology will be provided in separate technical guidance.

4.10.3. Based on Contractor performance, CMS will recoup the Medicare A/B penalty retroactively, once performance for the applicable Demonstration year has been determined.

4.11. American Recovery and Reinvestment Act of 2009. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.11.1. Suspension of Payments. DHCS shall suspend payments to Cal MediConnect in accordance with 42 C.F.R. § 455.23as as determined necessary or appropriate by DHCS.

4.11.2. Non-Payment and Reporting of Provider Preventable Conditions. Pursuant to 42 C.F.R. § 438.3(g), all payments to the Contractor are conditioned on the Contractor's compliance with all provisions related to Provider Preventable Conditions in accordance with the applicable DPL(s) as indicated in Section 2.1.5.

4.12. Medical Loss Ratio (MLR)

4.12.1. For Medicaid rating periods beginning on or after July 1, 2017, the Contractor is required to calculate and report their MLR experience for Medicaid, consistent with the requirements at 42 C.F.R. §§ 438.4, 438.5, 438.8 and 438.74, unless a joint MLR covering both Medicare and Medicaid experience is calculated and reported consistent with CMS and DHCS requirements.

4.12.2. Prior to the applicability of the requirements in 4.4.1 for all Demonstration Years in which the risk corridor applies, the Medicare Advantage MLR requirements are waived. To the extent the risk corridor ceases prior to the applicability of the requirements in 4.4.1 the Medicare Advantage MLR requirements will be reinstated for any applicable years in which the risk corridor is not in effect.

4.13. Risk Score Changes

4.13.1. Medicare Risk Score Changes: Medicare CMS-HCC, CMS-HCC ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.14. Reconciliation

4.14.1. CMS and DHCS will implement a process to reconcile enrollment and capitation payments for the Contractor that will take into

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consideration the following circumstances: transitions between RCs; retroactive changes in eligibility, RCs, or Enrollee contribution amounts; changes in CMS-HCC and RxHCC risk scores; and changes through new enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.

4.14.2. Identified Overpayments

4.14.2.1. The Contractor shall promptly report to DHCS and CMS any such identified overpayments due to Fraud.

4.14.2.2. The Contractor shall report to DHCS and CMS within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

4.14.2.3. Recoveries by the Contractor of overpayments to providers. Consistent with Section 1128J(d) of the Social Security Act, the Contractor must adopt and implement policies for the treatment of recoveries of overpayments from the Contractor to a Network Provider.

4.14.3. Medi-Cal Component Reconciliation. The Medi-Cal Component reconciliation will occur a minimum of once a month. The monthly reconciliation process will reconcile retroactively up to twelve (12) months of historical enrollment changes or up to the effective date of the contract, whichever is sooner.

4.14.3.1. The Contractor is at full risk for IHSS Provider payments. On a quarterly basis, DHCS shall reconcile Actual IHSS expenditures against the IHSS Interim Payment. If Actual IHSS expenditures exceed the Interim Payment amount, DHCS shall invoice the Contractor for the difference with a thirty (30) day due date. DHCS shall pay California Department of Social Services within two (2) weeks of receipt from the Contractor. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.14.4. Medicare Capitation Reconciliation: Medicare capitation reconciliation will comply with prevailing Medicare Advantage regulations and processes.

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4.14.4.1. Final Medicare Reconciliation and Settlement: In the event the Contractor terminates or non-renews this Contract, CMS' final settlement phase for terminating contracts applies. This final settlement phase lasts for a minimum of eighteen (18) months after the end of the calendar year in which the termination date occurs. This final settlement will include reconciliation of any demonstration-specific payments or recoupments, including those related to joint Medicare A/B-Medicaid risk corridors, quality withholds, and medical loss ratios, as applicable, that are outstanding at the time of termination.

4.14.5. Audits/Monitoring: CMS and DHCS will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and DHCS.

4.15. Payment in Full

4.15.1. The Contractor must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

4.15.2. Notwithstanding any contractual provision or legal right to the contrary, the three (3) parties to this Contract (CMS, DHCS, and the Contractor), for Cal MediConnect agree there shall be no redress against either of the other two (2) parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.15.3. By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the federal government to the Contractor, any entity participating in Cal MediConnect must rely on their own resource to project likely experience under Cal MediConnect.

5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes. The Contractor must notify CMS and DHCS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and DHCS in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The Contractor must notify CMS and DHCS in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment. The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and DHCS which may be withheld for any reason or for no reason at all.

5.1.3. Independent Contractors

5.1.3.1. The Contractor, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers, agents, or employees of the federal government, or DHCS.

5.1.3.2. The Contractor must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated, as provided for in Appendix C.

5.1.4. Subrogation. Subject to CMS and DHCS lien and third-party recovery rights, the Contractor must:

5.1.4.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer for other than Medi-

Cal and Medicare covered benefits, to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

5.1.4.2.1. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

5.1.4.2.2. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations. In accordance with 42 U.S.C. § 1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent (5%) of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor.

5.1.6. Disclosure Requirements. The Contractor must disclose to CMS and DHCS information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The Contractor must obtain federally required disclosures from all Network Providers and applicants in accordance 42 C.F.R. § 1002.3, and as specified by DHCS, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to DHCS in accordance with this Contract and relevant State and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. In addition, the Contractor shall make the information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to its Enrollees upon reasonable request.

5.1.7. Physician Incentive Plans.

5.1.7.1. The Contractor and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.3(i), and 1003. The Contractor must submit all information required to be disclosed to CMS and the DHCS in the manner and format specified by CMS and the DHCS which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.2. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the DHCS that results from the Contractor's or its First Tier, Downstream, or Related Entities' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003, however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and the DHCS, that it has made a good faith effort to comply with the cited requirements. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).

5.1.7.3. Contractor may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual.

5.1.7.4. Contractor must provide information on its PIP to any Enrollee upon request as provided in 42 C.F.R. § 422.208.

5.1.8. Physician Identifier. The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The Contractor must provide such unique identifier to CMS and DHCS for each of its PCPs in the format and time-frame established by CMS and DHCS in consultation with the Contractor.

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5.1.9. Timely Provider Payments. The Contractor must make timely payments to its Network Providers consistent with 42 C.F.R. § 447.45. The Contractor must ensure that ninety percent (90%) of claims from Network Providers (including Indian Health Care Providers) who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within thirty (30) days of the date of receipt of the claim. In addition, ninety-nine percent (99%) of all clean claims from Network Providers will be paid within ninety (90) days of the date of receipt of the claim. The Contractor and its Network Providers may by mutual agreement, in writing, establish an alternative payment schedule. Generally, the date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.9.1. Pharmacy providers will be reimbursed in accordance with the prompt payment provisions at 42 C.F.R. § 423. 505(i)(3)(vi).

5.1.9.2. The Contractor shall pay ninety-five percent (95%) of clean claims from non-contracted providers within thirty (30) days of request. All other claims shall be paid or denied within sixty (60) days of request.

5.1.10. Provider Payments. The Contractor shall pay providers in accordance with Medicare and Medi-Cal coordination of benefits, per WIC Section 14182.16 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

5.1.10.1. Medi-Cal Alignment. The Contractor shall pay providers, including institutional providers, in accordance with the prompt payment provisions in compliance with 42 C.F.R. § 447.45, ARRA 5006(d) and as contained in each Contractor's Medi-Cal managed care contract with DHCS, including the ability to accept and pay electronic claims, excluding Part D.

5.1.10.2. Date of Receipt. The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.10.3. Nursing Facility Rates. The Contractor shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and

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chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services. The Contractor shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services.

5.1.11. Protection of Enrollee-Provider Communications. In accordance with 42 USC § 1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a clinical First Tier, Downstream or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

5.1.12. Protecting Enrollee from Liability for Payment. The Contractor must:

5.1.12.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.12.1.1. Debts of the Contractor, in the event of the Contractor's insolvency;

5.1.12.1.2. Covered Services provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or DHCS for such services; or

5.1.12.1.3. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

5.1.12.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A below;

5.1.12.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge; and

5.1.12.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

5.1.13. Third Party Liability (TPL)

5.1.13.1. General Requirements.

5.1.13.1.1. Coordination of Benefits means the process of utilizing TPL resources to ensure that Medi-Cal is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or the method of post-payment recovery of the cost of services, if the coverage is identified retroactively.

5.1.13.1.2. DHCS shall refer to the Contractor the Enrollee's name and pertinent information where DHCS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

5.1.13.1.3. The Contractor shall identify and notify the DHCS's TPL and Recovery Division of all instances or cases in which Contractor believes an action by the Enrollee involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Enrollee of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, WIC. Contractor shall make no claim for recovery of the value of Covered Services rendered to an Enrollee in such cases or instances and such case or instance shall be referred to State's TPL Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

5.1.13.1.3.1. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an Enrollee, Contractor shall deliver the requested information within thirty (30) calendar days of the request. Service information includes First Tier, Downstream, or Related Entity and out of plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to First Tier, Downstream, or Related Entity providers or out of plan providers for similar services, whichever is applicable under WIC Section 14124.90(c)(2).

5.1.13.1.3.2. Designate a TPL Benefit Coordinator who shall serve as a contact person for benefit coordination issues related to this Contract.

5.1.13.1.3.3. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

5.1.14. Medicaid Drug Rebate

5.1.14.1. Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the State is subject under section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.

5.1.14.2. Contractor shall submit to DHCS, on a timely and periodic basis, no later than forty-five (45) calendar days after the end of each quarterly rebate period, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage and other data as DHCS determines necessary.

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5.1.15. Moral or Religious Objections. The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, pay for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

5.1.15.1. To the State;

5.1.15.2. With its application for a contract;

5.1.15.3. Whenever it adopts the policy during the term of the Contract; and the information provided must be:

5.1.15.3.1. Consistent with the provisions of 42 C.F.R. § 438.10;

5.1.15.3.2. Provided to Eligible Beneficiaries before and during enrollment; and

5.1.15.3.3. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.2. Confidentiality

5.2.1. Statutory Requirements. The Contractor understands and agrees that CMS and DHCS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 C.F.R., Parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal information under the California Information Practices Act (Civil Code Section 1798 et seq.). The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under

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this Contract in accordance with applicable State and federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C. § 552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Personal Data. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

5.2.3. Data Security. The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. § 164.530(c). The Contractor must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, subpart C, the HIPAA Security Rule. Contractor must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

5.2.4. Return of Personal Data. The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or DHCS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or DHCS will destroy such data or material.

5.2.5. Research Data. The Contractor must seek and obtain prior written authorization from CMS and DHCS for the use of any data pertaining

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to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.3. General Terms and Conditions

5.3.1. Applicable Law. The term "applicable law," as used in this Contract, means, without limitation, all federal and California law, and the regulations, policies, procedures, and instructions of CMS and DHCS all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2. Sovereign Immunity. Nothing in this Contract will be construed to be a waiver by the State of California or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medi-Cal program.

5.3.4. Loss of Licensure. If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or State approvals, the Contractor must report such loss to CMS and DHCS. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification. The Contractor shall indemnify and hold harmless CMS, the federal government, and DHCS from and against any and all liability, loss, damage, costs, or expenses which CMS and or DHCS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that:

5.3.5.1. The Contractor is notified of any claims within a reasonable time from when CMS and DHCS become aware of the claim; and

5.3.5.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

5.3.6. Prohibition against Discrimination.

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5.3.6.1. In accordance with 42 USC § 1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the Contractor's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or State law, solely on the basis of such license or certification. This section does not prohibit the Contractor: from including providers in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees; from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

5.3.6.2. Contractor will give written notice of the reason for its decision when it declines to include individual or groups of providers in its network.

5.3.6.3. If a Complaint or claim against the Contractor is presented to DHCS or CMS, the Contractor must cooperate with in the investigation and disposition of such Complaint or claim.

5.3.7. Anti-Boycott Covenant. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by DHCS. Without limiting such other rights as it may have, CMS and DHCS will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one percent (51%) of the ownership interests of the Contractor.

5.3.8. Other Contracts. Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health Care Plans or providing health care services to persons other than those eligible for coverage in the Contract; provided, however, that the Contractor must provide CMS and DHCS with a complete list of such plans and services, upon request. CMS and DHCS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or DHCS

from contracting with other comprehensive health Care Plans, or any other provider, in the same Service Area.

5.3.9. Counterparts. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.10. Entire Contract. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.11. No Third-Party Rights or Enforcement. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.12. Corrective Action Plan. If, at any time, CMS and DHCS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS and DHCS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and DHCS will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by CMS and DHCS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and DHCS or other intermediate sanctions as described in Section 5.3.13.

5.3.13. Intermediate Sanctions.

5.3.13.1. In addition to termination under Section 5.5, CMS and DHCS may, impose any or all of the sanctions in Section 5.3 upon any of the events below; provided, however, that CMS and DHCS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. CMS and DHCS may choose to provide warning notices and/or corrective action plans before sanctions. Sanctions may be imposed in accordance with this section for any failure to comply with this Contract, including but not limited to, if the Contractor:

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5.3.13.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.3.13.1.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.3.13.1.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, or uses any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.13.1.4. Misrepresents or falsifies information provided to CMS, DHCS, Enrollees, or its Provider Network;

5.3.13.1.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);

5.3.13.1.6. Fails to comply with federal or State statutory or regulatory requirements related to this Contract;

5.3.13.1.7. Violates restrictions or other requirements regarding marketing;

5.3.13.1.8. Fails to comply with quality management requirements consistent with Section 2.16;

5.3.13.1.9. Fails to comply with any corrective action plan required by CMS and DHCS;

5.3.13.1.10. Fails to comply with financial solvency requirements;

5.3.13.1.11. Fails to comply with reporting requirements; or

5.3.13.1.12. Fails to comply with any other requirements of this Contract.

5.3.13.2. Such sanctions may include, but are not limited to:

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5.3.13.2.1. Intermediate sanctions and civil monetary penalties consistent with 42 C.F.R. § 422 Subpart O or § 438 Subpart I;

5.3.13.2.2. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);

5.3.13.2.3. Suspension of enrollment (including assignment of Enrollees);

5.3.13.2.4. Suspension of payment to the Contractor;

5.3.13.2.5. Disenrollment of Enrollees; and

5.3.13.2.6. Suspension of marketing.

5.3.13.2.7. Denial of payment as set forth in 42 C.F.R. § 438.730.

5.3.13.3. If CMS or DHCS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.3.12, CMS and DHCS may:

5.3.13.3.1. Require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and DHCS; or

5.3.13.3.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

5.3.13.4. Additional Administrative Procedures. CMS and DHCS may, from time to time, issue program memoranda, bulletins, and DPLs clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda, bulletins, and letters as may be issued from time to time.

5.3.13.5. Effect of Invalidity of Clauses. If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.14. Before imposing any intermediate sanctions, consistent with 42 C.F.R. § 438.710, DHCS and CMS must give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that DHCS and CMS elect to provide.

5.3.15. Conflict of Interest. Neither the Contractor, nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and DHCS with the performance of services under the Contract, or that may be otherwise anticompetitive. The Contractor further certifies that it will comply with Section 1932(d) of the Social Security Act.

5.3.16. Insurance for Contractor's Employees. The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including but not limited to, worker's compensation and unemployment compensation, and must provide CMS and DHCs with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of CMS or DHCS, provide certification of professional liability insurance coverage.

5.3.17. Waiver. The Contractor, CMS, or DHCS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or DHCS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and DHCS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.18. Section Headings. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audit

5.4.1. The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years from the end of the final contract period or completion of audit, whichever is later.

5.4.2. The Contractor must make the records maintained by the Contractor and its Provider Network, as required by CMS and DHCS and other regulatory agencies, available to CMS and DHCS and its agents, designees or contractors or any other authorized representatives of the State of California or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.

5.4.3. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.4. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or DHCS may require, in a manner that meets CMS and DHCS record maintenance requirements.

5.4.5. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten (10) years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and State requirements.

5.4.6. Disputes. The Disputes procedure set forth in Appendix K will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

5.5. Termination of Contract

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5.5.1. Termination without Prior Notice. In the event the Contractor substantially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Medi-Cal programs, CMS or DHCS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract in accordance with regulations that are current at the time of the termination.

5.5.2. Without limiting the above, if CMS or DHCS determine that participation of the Contractor in the Medicare or Medi-Cal program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or Medi-Cal program, CMS or DHCS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any Contractor, and shall be taken upon a finding by CMS or DHCS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medi-Cal services to Medicare-Medi-Cal beneficiaries.

5.5.3. United States law and California law, as appropriate, will apply to resolve any claim of breach of this Contract.

5.5.4. Termination with Prior Notice.

5.5.4.1. CMS or DHCS may terminate this Contract without cause upon no less than one hundred eighty (180) days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.8, the Contractor may choose to non-renew this Agreement prior to the end of each term pursuant to 42 C.F.R. § 422.506(a). In considering requests for termination under 42 C.F.R. § 422.508, CMS and DHCS will consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and DHCS prior to their use.

5.5.4.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in paragraph 5.5.2.1 and non-renewal of

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this Contract as described in Section 5.8 to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

5.5.5. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.6. Termination for Cause. Any party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or DHCS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or DHCS may expedite the termination.

5.5.6.1. Pre-termination Procedures. Before terminating a contract under 42 C.F.R. § 422.510 and § 438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or DHCS must:

5.5.6.1.1. Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.6.1.2. Notify the Contractor of its Appeal rights as provided in 42 C.F.R. § 422 Subpart N and § 438.710.

5.5.6.2. If Contractor fails to comply with the provisions of Section 5.5, CMS or DHCS may terminate this agreement upon thirty days' notice.

5.5.7. Termination due to a Change in Law. In addition, CMS or DHCS may terminate this agreement upon thirty (30) days notice due to a material change in law, or by operation of law, including a change in the State law authorizing the State's participation in the program, or with less or no notice if required by law.

5.5.8. Continued Obligations of the Parties.

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5.5.8.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or Medi-Cal programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that CMS and DHCS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

5.5.8.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.8.2.1. If CMS or DHCS, or both, elect to terminate the Contract, CMS and DHCS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care under applicable laws, regulations, and provisions of this Contract. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements and the terms of this Contract;

5.5.8.2.2. The Contractor must promptly return to CMS and DHCS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and

5.5.8.2.3. The Contractor must supply to CMS and DHCS all information necessary for the payment of any outstanding claims determined by CMS and DHCS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

5.6. Impact of Termination

5.6.1. In the event this Contract is terminated, expires, or is not renewed for any reason, the State shall have the authority to crosswalk Enrollees

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into a Medi-Cal Managed Care Plan for the purposes of the seamless provision of Medi-Cal managed care Covered Services.

5.6.2. The State shall provide such Enrollees with notice of this crosswalk and of any options Enrollees have to change Medi-Cal managed care plans for the provision of Medi-Cal Covered Services.

5.7. Order of Precedence

5.7.1. The following documents are incorporated into and made a part of this Contract:

5.7.1.1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;

5.7.1.2. DHCS's Bridge to Health Reform Section 1115 waiver as amended for purposes of this demonstration;

5.7.1.3. CFAM-MOU, a document between CMS and DHCS regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27, 2013);

5.7.1.4. The Contractor's Medi-Cal managed care contract;

5.7.1.5. All applicable federal and State regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, the annual rate report, plan letters, bulletins and guidance memoranda.

5.7.1.6. The Contractor's response to the Request for Solutions.

5.7.2. In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

5.7.2.1. The Contract terms and conditions, including all appendices;

5.7.2.2. Capitated Financial Alignment Application;

5.7.2.3. DHCS's Bridge to Health Reform Section 1115 waiver as amended for purposes of this demonstration;

5.7.2.4. CFAM-MOU, a document between CMS and DHCS Regarding a federal-State partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27. 2013);

5.7.2.5. The Contractor's Medi-Cal managed care contract;

5.7.2.6. All applicable federal and State regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, bulletins, and guidance memoranda; and

5.7.2.7. The Contractor's response to the RFS.

5.7.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.8. Contract Term.

5.8.1. This Contract shall be in effect starting from the date on which all parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2022, so long as the Contractor has not provided CMS and the State with a notice of intention not to renew, and CMS/State have not provided the Contractor with a notice of intention not to terminate, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above This contract will terminate, or its effectuation will be delayed, unless the State receives all necessary approvals from CMS, including but not limited to § 1115(a) demonstration authority, and unless the Contractor is deemed ready to participate in the MMCO demonstration, as provided for in Section 2.2.1.3 of this Contract. Funds must not be expended or awarded until the State has received all necessary approvals from CMS. No payments will be made nor Medicaid federal Medical assistance payment (FMAP) funds drawn for any services provided or costs incurred prior to the later of the approval date for any necessary § 1115(a) authority, the Readiness Review approval, or the effective date of this Contract.

5.9. Amendments

5.9.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions,

provided that such amendment is in writing, signed by authorized representatives of all three parties, and attached hereto.

5.10. Written Notices

5.10.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

To: California Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413
Sacramento, CA 95899-7413

To: Orange County Health Authority
505 City Parkway West
Orange, CA 92868

Email Copies to:
Silver Ho sho@caloptima.org

Annie Phillips aphillips@caloptima.org

Gisela Gomez ggomez@caloptima.org

Michael Schrader mschrader@caloptima.org

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Contractor:

	10/31/19
Paul Yost, Chair, CalOptima Board of Directors	Date

Orange County Health Authority

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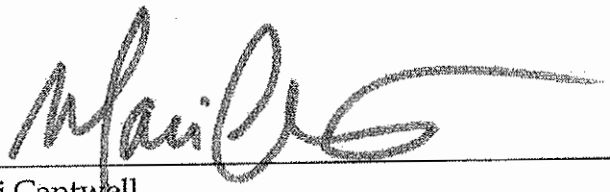
In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:



Date 9/17/19

Mari Cantwell
Chief Deputy Director
Health Care Programs
State Medicaid Director
California Department of Health Care Services

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Trinia J. Hunt

Trinia J. Hunt
Acting Director
Division of Medicaid Field Operations West
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

9/20/2019
Date

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:



9/16/19
Date

Kathryn A. Coleman
Director
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

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SECTION 6: Appendices

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Appendix A: Covered Services

The Contractor shall provide services to Enrollees as follows:

A.1 Medical Necessity. The Contractor shall provide services to Enrollees as follows:

A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Covered Services that are Medically Necessary as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.2.1. Prevent, diagnose, or treat health impairments;

A.1.2.2. Attain, maintain, or regain functional capacity.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.

A.1.5 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

A.1.5.1. Developed with input from practicing physicians in the Cal MediConnect's Service Area;

A.1.5.2. Developed in accordance with standards adopted by national accreditation organizations;

A.1.5.3. Developed in accordance with the definition of Medical Necessity in Section 2.4;

A.1.5.4. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.5.5. Evidence-based, if practicable; and

A.1.5.6. Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.6 The Contractor's Medical Necessity guidelines, program specifications and service components must, at a minimum, be submitted to DHCS annually for approval no later than 60 days prior to the start of a new Contract Year, and no later than 60 days prior to any change.

A.1.7 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received CMS and DHCS approval.

A.2 Covered Services. Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All standard Medi-Cal fee-for-service benefits excluding:

A.2.1.1. ICF/MR services;

A.2.1.2. County-administered Medi-Cal Specialty Mental Health Services and substance use disorder services. This does not include Behavioral Health services that become Medi-Cal managed care benefits on January 1, 2014, pursuant to Welfare and Institutions Code Section 14132.03, which will be Covered Services under this contract;

A.2.1.3. State and County activities to administer IHSS, including determining eligibility, assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, enrolling providers, conducting provider orientation, and retaining enrollment documentation, conducting criminal background checks on all potential providers, providing assistance to IHSS recipients in finding eligible providers through an established provider registry;

A.2.1.3.1 For dates of service on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97);

A.2.1.4. Medi-Cal Dental Services, known as Denti-Cal

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Particular pharmacy products that are covered by Medi-Cal and may not be covered under Medicare Part D.

- Contractors are encouraged to offer a broader drug formulary than minimum requirements.

A.3 In addition, Contractor agrees to provide the following:

A.3.1 Vision Benefit

A.3.1.1. $0 copay for one (1) routine eye exam every year

A.3.1.2. Every two years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses

A.3.2 Non-Medical Transportation and Non-Emergency Medical Transportation Benefits

A.3.2.1. Contractors must provide transportation services to beneficiaries for Medically Necessary Services.

A.3.2.2. Contractors must provide transportation services pursuant to this Contract, applicable law including but not limited to Welfare & Institutions Code 14132(ad) and the requirements in applicable current and future DPLs.

A.3.3 Care Transitions Assistance provided across facility and community settings. Care Coordination shall be provided for transitions among levels of care and between service locations. Such services facilitate safe and coordinated transitions across care settings, which may be particularly appropriate for Enrollees who have experienced or are expecting an inpatient stay.

A.4 Cost-sharing for Covered Services

A.4.1 Except as described below, cost-sharing of any kind is not permitted in Cal MediConnect.

A.4.1.1. Co-pays charged by Demonstration Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.4.1.2. The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

A.4.1.3. Co-pays charged by Demonstration Plans for supplemental dental benefits.

A.5 Limitations on Covered Services.

A.5.1 – Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.5.2 –Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).

Appendix B: Enrollee Rights

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the CFAM-MOU. Specifically, Enrollees must be guaranteed:

A. The right to be treated with dignity and respect.
B. The right to be afforded Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
D. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
E. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
F. Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
G. The right to choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.
H. The right to participate in all aspects of care and to exercise all rights of Appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:
    a. Receive a comprehensive Health Risk Assessment upon date of coverage in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination of Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
    b. Receive complete and accurate information on his or her health and

Functional Status by the interdisciplinary team.

c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
    i. Before enrollment.
    ii. At enrollment.
    iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.
d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
e. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
f. Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

I. The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
J. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
K. Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the DHCS treat the Enrollee.
L. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and, the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 438.10 for G and H.
M. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.
N. The right not to be charged any cost sharing for Medicare Parts A and B services.
O. The unconditional and exclusive right to hire, fire, and supervise his or her IHSS provider.
P. The right to receive their Medicare and Medi-Cal Appeals rights in a format and language understandable and accessible to them.
Q. The right to opt out of Cal MediConnect at any time, beginning at the first of the

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following month.

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Appendix C: Relationship with First Tier, Downstream, and Related Entities

A. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§422.504, 423.505, and 438.3(k).

B. Contractor shall specifically ensure:
   1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
   2. HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

C. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
   1. Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;
   2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and DHCS; including the requirements at 42 C.F.R. § 438.414 in relation to the Grievance system.
   3. Language that specifies the delegated activities and reporting requirements;
   4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, DHCS or the Contractor determine that such parties have not performed satisfactorily;
   5. Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary;
   6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and
   7. Language that specifies the First Tier, Downstream and Related Entities must comply with all federal and State laws, regulations and CMS instructions.

D. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:
   1. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Contractor; or
   2. The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.

E. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must

include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

F. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a provider of the reason or reasons for termination with cause.

G. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:

1. Language that the Contractor is obligated to pay contracted medical providers under the terms of the contract between the Contractor and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the relevant medical provider;
2. Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
3. Language that medical providers abide by all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;
4. Language that medical providers ensure that medical information is released in accordance with applicable federal or State law, or pursuant to court orders or subpoenas;
5. Language that medical providers maintain Enrollee records and information in an accurate and timely manner;
6. Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them; and
7. Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.
8. Language that clearly states the medical providers' EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
9. Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.
10. Language that prohibits the Contractor from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
    (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or
    (b) Communicated with one or more of his or her prospective, current or former

patients with respect to the method by which such provider is compensated by the Contractor for services provided to the patient.

11. Language that states the provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions.
12. Language that specifies the term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.
13. Full disclosure of the method and amount of compensation or other consideration to be received from the Contractor.
14. Language that requires the medical provider to assist Contractor in the transfer of care.
15. Language that requires the medical provider to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.
16. Notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.
17. Assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
18. Timely gather, preserve and provide to DHCS, any records in the subcontractor's possession.
19. Provide interpreter services for Enrollees at all provider sites.
20. Right to submit a Grievance and Contractor's formal process to resolve Provider Grievances.
21. To participate and cooperate in the Contractor's Quality Improvement System.
22. If Contractor delegates Quality Improvement activities, Subcontract shall include provisions as specified by DHCS.

Appendix D: Quality Improvement Requirements

The Contractor will undertake the following quality improvement initiatives with the goal of identifying areas in need of improvement and undertaking quality improvement activities in response to the findings related to each initiative.

1. Emergency Department utilization. The goal of this initiative is to better understand reasons for ED utilization among Cal MediConnect Enrollees, and the impact of LTSS to such usage.
    - Contractor will identify a random sample of Enrollees each year who have utilized ED services. [
    - Contractor will engage an independent quality assurance entity to conduct interviews with each Enrollee in the sample to determine background & causes for ED visits, using a semi-structured interview tool provided by DHCS.
    - Contractor will analyze results of the surveys in order to understand the underlying causes of ED utilization, including the use of and/or or failure of LTSS, or there was a lack of appropriate LTSS to adequately support the Enrollee in his or her environment. Contractor will identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency department services.
    - Contractor will report results to DHCS and to CMS.

2. Barriers to Health Access. The goal of this initiative is to better understand access issues experienced by Cal MediConnect Enrollees.
    - Contractor will identify a random representative sample size of Enrollees each year.
    - An independent quality assurance entity will conduct interviews with each Enrollee in the sample, using a semi-structured interview tool provided by DHCS, to determine if any barriers to health care were experienced and to understand the nature of those barriers. Examples of barriers include, but are not limited to, the following: inaccessible medical equipment in provider offices, inaccessible signage in provider

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offices (i.e. no Braille writing on signs), inaccessible communication from the Cal MediConnect or providers (i.e. no access to ASL interpreters, no written communication in large print or plain language, or no access to someone who can explain information), inadequate access to appropriate physicians for intellectually disabled Enrollees, and incomplete or poor care due to negative attitudes about disability and/or recovery from providers.

Contractor will analyze results of the surveys in order to understand the underlying causes of these barriers to health care access. Contractor will identify issues within its system of care that require improvement to promote access and ADA

3. Other topic areas to be identified through annual guidance by CMS and DHCS in accordance with 42 C.F.R. § 422.152(c) and 422.152(d).

Appendix E: Addendum to Capitated Financial Alignment Contract

PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS"), the State of California, acting by and through the Department of Health Care Services (DHCS), and Orange County Health Authority, a Medicare-Medicaid managed care organization (hereinafter referred to as Contractor) agree to amend the contract H8016 governing Contractor's operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

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Article I

Voluntary Medicare Prescription Drug Plan

A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 [(hereinafter collectively referred to as "the addendum"). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, DHCS, and CMS.

Article II
Functions to be Performed by Contractor

A. ENROLLMENT

1. Contractor agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have elected to enroll in Contractor's Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, communication, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. §423.48.

2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the Contract year as provided in 42 C.F.R. §423.505(o).

3. Contractor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Communications and Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. Contractor agrees to address Complaints received by CMS against the Contractor as required in 42 C.F.R. §423.505(b)(22) by:

   (a) Addressing and resolving Complaints in the CMS Complaint tracking system; and

   (b) Displaying a link to the electronic Complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO CONTRACTOR

Contractor and CMS and DHCS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, DHCS and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and DHCS (as defined in Appendix I) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and DHCS that meet the requirements of 42 C.F.R. §423.120.

2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.

3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).

4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18), including making standard contracts available on request in accordance with the timelines specified in the regulation.

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

Contractor must provide certifications in accordance with 42 C.F.R. §423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. Contractor shall submit prescription drug event data in accordance with 42 C.F.R. §423.329(b)(3).

P. CONTRACTOR REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the cost of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. Contractor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

3. Contractor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to Contractor for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS AND DHCSLICENSE FOR USE OF CONTRACTOR FORMULARY

Contractor agrees to submit to CMS and DHCS the Contractor's formulary information, including any changes to its formularies, and hereby grants to the

Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. Contractor agrees to comply with the confidentiality and Enrollee record accuracy requirements specified in 42 C.F.R. §423.136.

B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2013. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if—

   (a) Contractor has not provided CMS or DHCS with a notice of intention not to renew in accordance with Article VII of this addendum

2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and DHCS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the Appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VI
Nonrenewal of Addendum By Contractor

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A. Contractor may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article IX
Termination of Addendum by Contractor

A. Contractor may terminate this addendum only in accordance with 42 C.F.R. 423.510.

B. If the addendum is terminated under section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article X
Relationship between Addendum and Capitated Financial Alignment Contract

A. Contractor acknowledges that, if it is a Capitated Financial Alignment contractor, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the Contractor's Capitated Financial Alignment Contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. §422.4(c), in which case the Contractor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment Contract to which this document is an addendum.

C. In the event that Contractor's Capitated Financial Alignment Contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate.

In such an event, Contractor, DHCS and CMS shall provide notice to Enrollees and the public as described in this Contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND DHCS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and DHCS' approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and DHCS systems to process enrollment applications (or contracting with an entity qualified to

perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

Appendix F: Data Use Attestation

The Contractor shall restrict its use and disclosure of Medicare and Medi-Cal data obtained from CMS and DHCS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and DHCS to administer. The Contractor shall only maintain data obtained from CMS and DHCS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and DHCS to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or DHCS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the Contractor contracted with CMS and DHCS.

The Contractor further attests that it shall limit the use of information it obtains from its Medicare-Medicaid Enrollees to those purposes directly related to the administration of such plan. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Medicare-Medicaid Enrollees information about non-health related services after obtaining consent. Second, the Contractor may provide information about health-related services without obtaining prior consent, as long as the Contractor affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Enrollees beyond the scope for which CMS and DHCS have authorized under this agreement. A termination of this data use agreement may result in CMS or DHCS terminating the Contractor's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an Integrated Care Organization (Cal MediConnect). This agreement shall remain in effect as long as the Contractor remains a Cal MediConnect sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or DHCS make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

Appendix G: Model File & Use Certification Form

Pursuant to the Contract between the Centers for Medicare & Medicaid Services (CMS), the State of California, acting by and through the Department of Health Care Services (DHCS) and Plan hereafter referred to as the Contractor, governing the operations of the following health plan: Orange County Health Authority, the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or DHCS to be misleading or inaccurate or that do not follow established Medicare Communications and Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. §§422.2260 – 422.2276 and 42 C.F.R. §422.111 for Cal MediConnect and the Medicare Communications and Marketing Guidelines.

I agree that CMS or DHCS may inspect any and all information including those held at the premises of the Contractor to ensure compliance with these requirements. I further agree to notify CMS and DHCS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor.

Appendix H: Medicare Mark License Agreement

THIS AGREEMENT is made and entered into January 1, 2018

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

Orange County Health Authority (hereinafter "Licensee"),
with offices located at 505 City Parkway West, Orange, CA 92868.

CMS Contract ID: H8016

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WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning September 1, 2019.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Communications and Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2019, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2019, this agreement shall be renewable for

successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

Appendix I: Service Area

The Service Area outlined below is contingent upon the Contractor meeting all Readiness Review requirements in each county. CMS and DHCS reserve the right to amend Appendix I to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and DHCS.

County Service Area:

Orange

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Appendix J: Eligible Populations

Enrollment into Cal MediConnect will be available to individuals who meet all of the following criteria:

- Age 21 and older at the time of enrollment;
- Entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, or enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan;
- Eligible for full Medicaid (Medi-Cal), including
    - Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
    - Individuals who meet the share of cost provisions described below:
        - Nursing facility residents with a share of cost,
        - MSSP Enrollees with a share of cost, and
        - IHSS recipients with a share of cost.
    - Individuals eligible for full Medicaid (Medi-Cal) per the spousal impoverishment rule codified at section 1924 of the Social Security Act as described below:
        - For those Enrollees who are nursing facility level of care, subacute facility level of care, or intermediate care facility level of care and reside or could reside outside of a hospital or nursing facility, the Department or its designee shall make a Medi-Cal eligibility determination "as if" the beneficiary were in a long-term care facility. Specifically, the spousal impoverishment rule codified section 1924 of the Act will apply to Enrollees. The terms "intermediate care facility level of care" and "nursing facility level of care" and "subacute facility level of care" shall have the same meaning as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- Reside in one of the following Demonstration counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
    - Up to 200,000 individuals in Los Angeles may be enrolled in the Demonstration. CMS and the State will monitor the enrollment and stop participation when this enrollment cap is met.
- Individuals residing in San Mateo or Orange county with a diagnosis of end stage renal disease (ESRD) at the time of enrollment.

The following populations will be excluded from enrollment:

- Individuals under age 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through California's regional centers or State developmental centers or intermediate care facilities for the developmentally

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disabled in Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara counties;

- Individuals with a share of cost that do not meet the requirements outlined above;
- Individuals residing in one of the Veterans' Homes of California;
- Individuals living in the following rural zip codes:
    - San Bernardino County – 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, and 93558
    - Los Angeles County - 90704
    - Riverside County - 92225, 92226, 92239;
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and residing in Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara, unless they are already enrolled in a separate line of business operated by the Contractor. Individuals enrolled in the Demonstration who are subsequently diagnosed with ESRD, as with all Enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

Individuals that may enroll but may not be passively enrolled include (see section C.2 for a description of Passive Enrollment):

- Individuals residing in the following rural zip codes in San Bernardino County in which only one Cal MediConnect Plan operates: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398;
- Individuals enrolled in Medicare Advantage in 2014;
- Individuals in one of the following programs may enroll only after they have disenrolled from the program:
    - Individuals enrolled in the following 1915(c) waivers: Nursing Facility/Acute hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver; and
    - Individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

Appendix K: Disputes

Contractor also agrees to the following:

1. This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues. It shall not be used with respect to any dispute regarding the actuarial soundness of the capitated rate, as provided in paragraph 4.6.2. Filing a dispute will not preclude DHCS and CMS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds twenty-five (25) percent of the capitation payment, amounts of up to twenty-five (25) percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.
2. Disputes Resolution by Negotiation
    a. DHCS, CMS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contract Management Team (CMT) without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.
3. Notification of Dispute
    a. Within fifteen (15) calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the CMT in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.
    b. The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:
        i. That it is a dispute pursuant to this section.
        ii. The date, nature, and circumstances of the conduct which is subject of the dispute.
        iii. The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/State official or CMS employee involved in or knowledgeable about the conduct.
        iv. The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.
        v. The reason the Contractor is disputing the conduct.
        vi. The cost impact to the Contractor directly attributable to the alleged conduct, if any.
        vii. The Contractor's desired remedy.

c. The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent Appeal.

d. Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22 CCR Section 53851(d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

4. CMT or Alternate Dispute Officer's Decision

a. Pursuant to a request by Contractor, the CMT may provide for a dispute to be decided by an alternate dispute officer designated by DHCS and CMS, who is not a member of the CMT and is not directly involved in Medicare or the Medi-Cal Managed Care Program, as appropriate for the issue involved. Any disputes concerning performance of this Contract shall be decided by the CMT or the alternate dispute officer in a written decision stating the factual basis for the decision. Within thirty (30) calendar days of receipt of a Notification of Dispute, the CMT or the alternate dispute officer, shall either:

i. Find in favor of Contractor, in which case the CMT or alternate dispute officer may:

A. Countermand the earlier conduct which caused Contractor to file a dispute; or

ii. Or,

A. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

B. Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 calendar days to respond to the CMT or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the CMT or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the CMT or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with Paragraph F. Waiver of Claims, below. A copy of the decision shall be served on Contractor.

5. Appeal of CMT or Alternate Dispute Officer's Decision

a. Contractor shall have thirty (30) calendar days following the receipt of the decision to file an Appeal of the decision to the Director and the Medicare Drug & Health Plan Contract Administration Group Director, Center for Medicare. All Appeals

shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All Appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An Appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An Appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's Appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely Appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph 7, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Appendix K, Disputes, prior to initiating any other action to enforce this Contract.

6. Contractor Duty to Perform

    a. Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851(d) and proceed diligently with the performance of this Contract and in accordance with the CMT or alternate dispute officer's decision. If pursuant to an Appeal under Paragraph 5, Appeal of CMT or Alternate Dispute Officer's Decision above, the CMT or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph 5. shall be retroactive to the date of the CMT or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. CMS and DHCS shall not pay interest on any amounts paid pursuant to a CMT or alternate dispute officer's decision or any Appeal of such decision, or any subsequent court decision or court order regarding the subject matter of the Notification of Dispute.

7. Waiver of Claims

    a. If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an Appeal of the CMT or alternate dispute officer's decision, in the manner and within the time specified in this Appendix K, Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

Appendix L: Additional Medicare Waivers

In addition to the waivers granted for the Cal MediConnect demonstration in the MOU, CMS hereby waives Section 1860-D1 of the Social Security Act, as implemented in 42 C.F.R. § 423.38(c)((4)(i), and extend Sections 1851(a), (c), (e), and (g) of the Social Security Act, as implemented in 42 C.F.R. Part 422, Subpart B only insofar as such provisions are inconsistent with allowing dually eligible beneficiaries to change enrollment on a monthly basis.

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

California Advancing & Innovating Medi-Cal (CalAIM) Proposal

January 2021

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1. Executive Summary

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that targets social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services with the goal of improving outcomes for all Californians. Attaining such goals will have significant impact on an individuals' health and quality of life and, through iterative system transformation, will ultimately reduce the per-capita costs over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

1.1 Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations, as well as state-level statutory and policy changes. During this time, DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental,

developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

Together, these CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and the public hospital system delivery transformation, that advance the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated “wellness” system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make the system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

1.2 Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles for the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

1.3 Key Goals

To achieve these principles, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Below is an overview of the various proposals and recommendations that make up CalAIM. See **Appendix A: 2021 and Beyond: CalAIM Implementation Timeline** for more information.

1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the state's health care delivery system aimed at achieving better care and better health. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve these goals, DHCS proposes the following whole system, person centered approach that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Develop a statewide **population health management** strategy and require plans to submit local population health mangement plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure to build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail**.
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall provide, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and

- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care Pilots, and transitions those services to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs.

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of

risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

SMI/SED Demonstration Opportunity

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institution for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily

engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily "opt-in" to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

- Ensuring high quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community-based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this demonstration opportunity, counties that "opt-in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation, and overall integration back into the community are met. Studies have shown that these types of care coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate a county inmate Medi-Cal application process by January 2023. Additionally, DHCS is proposing to mandate that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around issues such as eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to the current realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected full integration plans would go live no sooner than 2027.

Develop a Long-Term Plan for Foster Care

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.

1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services vary depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and aligning delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental, and other county-based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long-term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance (NCQA) accredited
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 17 children preventive services codes and continuity of care through a Dental Home

County-Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contact and demographic information

Managed Care

Managed Care Enrollment

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Standardize Managed Care Benefits

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

Transition to Statewide Managed Long-Term Services and Supports

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

January 2023: Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service (FFS) Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent

with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to advance a high-quality continuum of care for mental health and SUD services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

Administrative Behavioral Health Integration

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

Behavioral Health Regional Contracting

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such

as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Program Renewal and Policy Improvements

DHCS proposes to update the DMC-ODS program, based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

- Add new dental benefits based on the outcomes and successes from the DTI that will provide better care and align with national oral health standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and

- Continue and expand Pay for Performance Initiatives initiated under the DTI that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult Medi-Cal enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS remains compliant with federal and state eligibility and enrollment requirements. These enhancements will be developed and implemented in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which beneficiary contact and demographic information can be updated by other entities and the means to accomplish this, while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

1.6 Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration's plan to respond to the state's homelessness crisis; support reforms of our justice systems for youth and adults who have significant health issues; build a platform for vastly more integrated systems of care; and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care, into the future of the program. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if approved and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal. This will ensure the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal and in Medicaid nationally. CalAIM proposes enhanced care management and in lieu of services (such as housing-related services, transitions, respite, and sobering centers) that address the clinical and non-clinical needs of these high-cost Medi-Cal beneficiaries. The initiative envisions a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services. It aligns the financing of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, and access to, integrated behavioral health care.

Vulnerable Children: CalAIM is designed to improve and streamline care for medically complex children to ensure they get their physical, behavioral, developmental, and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children, including identifying the complex impacts of trauma, toxic stress, and adverse childhood experiences through, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to the clinically-linked housing continuum for our homeless population, and would include housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.

Justice-Involved: Under the proposed Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health, and non-clinical social services for justice-involved individuals prior to and upon release from county jails and county juvenile

facilities. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for those who are incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the California's Master Plan for Aging.

1.7 From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system transformation in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of the managed care delivery system.

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training, including infection control measures, to address COVID. While the stay-at-home order and related delivery system changes slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California.

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g. counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

1.8 CalAIM Stakeholder Engagement

DHCS released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM proposal incorporates the broad range of

feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

1.9 Conclusion

CalAIM is an ambitious but necessary proposal to positively affect Medi-Cal beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, and ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.
- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.
- Builds capacity in a clinically-linked housing continuum via in lieu of services for California's homeless population, including housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

This section will walk through proposals to identify and manage member risk and need:

- Population Health Management Program
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings, and Incentive Payments
- SMI/SED Demonstration Opportunity
- Full Integration Plans
- Long-Term Plan for Foster Care

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement for Medi-Cal managed care plans to maintain a population health management (PHM) program, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care management – including assessing population level and individual member health risks and health-related social needs, creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs. Additionally, Medi-Cal managed care plans will develop predictive analytics about which members, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Medi-Cal managed care plans shall consult with their local public health department and county behavioral health department during the development of the population health management program.

The population health management program shall meet NCQA standards for population health, regardless of whether the plan is NCQA accredited. In addition to the NCQA accreditation processes, the population health management program description must be filed with the state via the population health management template (forthcoming). After the initial program description submission, the Medi-Cal managed care plan will submit certain portions of the program description, including any changes, to DHCS annually, but significant portions of the program description will only be required to be submitted to DHCS once every three years.

Each Medi-Cal managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination;
- Identify and mitigate social determinants of health; and
- Reduce health disparities or inequities.

The population health management program shall:

- Include the goal to improve the health outcomes of communities and groups;
- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement;
- Utilize initial and ongoing assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted interventions;
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, slow the progression of

disease or disability, and support members with serious illness as their disease progresses;

- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- Deploy strategies to address individual needs and mitigate social determinants of health;
- Deploy strategies to drive improvements in health for specific populations proactively identified as experiencing health disparities;
- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care.
- Utilize evidence-based practices in screening and intervention;
- Utilize a person-centered and family-centered approach for care planning; and
- Continually evaluate and improve on the population health management program strategy on an ongoing basis through meaningful quality measurement.

Assessment of Risk and Need

1. Initial Data Collection and Population Risk Assessment

As reflected in the NCQA Population Health program requirements and the DHCS Population Needs Assessment All Plan Letter (APL), the Medi-Cal managed care plan shall collect electronically available data sources in order to analyze data that capture the information on member health status and utilization (including physical, behavioral, and oral health), health-related social needs, and linguistic, racial, and cultural characteristics. As part of the population health management requirements, DHCS will continue to apply the existing Population Needs Assessment (PNA) APL requirements to hold the Medi-Cal managed care plans accountable for a PNA, which include requirements for analyzing health disparities and engaging external stakeholders as part of the process. DHCS will consult with NCQA to ensure the PNA APL data requirements meet NCQA data requirements for the population assessment.

The PNA requires that Medi-Cal managed care plans collect and analyze this data across the plan's entire Medi-Cal member population to identify opportunities at a population level to improve health. One example of how this might be done is through a type of analysis commonly known as "hot spotting." As noted in the PNA and NCQA

requirements, key issues Medi-Cal managed care plans must analyze in the assessment include:

- Acute, chronic, and prevention/wellness health needs;
- Areas of clinically inappropriate, over and under-utilization of health care resources;
- Opportunities for better care management and quality improvement;
- Health disparities by race, ethnicity, language, and functional status; and
- Health-related social needs at the community or local level.

The results of the PNA will inform the development of programs and strategies that the Medi-Cal managed care plan will use to address the needs of specific populations. Determining which individuals have access to these specific programs and strategies will be driven by the subsequent member-level risk stratification, population segmentation, and case management activities. Consistent with the PNA APL, Medi-Cal managed care plans must use the assessment to develop and implement an action plan to address community and population needs. DHCS does not currently plan to provide more specific requirements regarding community and population-level program development, but in the population health management template, Medi-Cal managed care plans will be asked indicate what they will be doing in this area, which also may be a focus of future learning collaborative best practice work.

2. Initial Risk Stratification, Segmentation and Tiering

Risk stratification or segmentation will enable Medi-Cal managed care plans to identify specific members who may benefit from wellness, prevention, and disease management activities; members who can benefit from case management; and members who are at risk for developing complex health issues. Consistent with NCQA Population Health program requirements, Medi-Cal managed care plans will be required to risk stratify and segment members into groups that it will use to develop and implement case management, wellness, and health improvement programs and strategies. Medi-Cal managed care plans will also be required to use DHCS-defined criteria to tier its members into four risk tier categories and report that information to DHCS.

Consistent with the NCQA Population Health program requirements, Medi-Cal managed care plans shall conduct the risk stratification and segmentation and DHCS risk tiering using an integrated data and analytics stratification process that considers at least the following sources:

- Previous screening or assessment data;
- Disengaged member reports;
- Claims or encounter data, including all fee-for-service data provided by DHCS;

- And to the extent available:
    - Available social needs data, including housing status ICD-10 data; and
    - Electronic health records.

Risk Stratification or Segmentation: Medi-Cal managed care plans will analyze each individual's data based on the minimum, mandatory list of data sources described above and will then risk stratify and segment members into meaningful sub-populations. The Medi-Cal managed care plan will use risk stratification and segmentation to identify specific members who may benefit from targeted interventions and programs designed to meet identified member needs. Risk stratification and segmentation must occur within 44 days of the effective date of plan enrollment.

The Medi-Cal managed care plan may use its own algorithm to risk stratify or segment its population or it may use the DHCS-defined risk tiers described below as a starting point for further stratification and segmentation. The design of the algorithm, including how the data is stratified and segmented as part of the algorithm, should be informed by the health needs identified through the population assessment and designed so that the Medi-Cal managed care plan can group individual members into meaningful categories and subsequently outreach to individual members within those categories for tailored interventions and programs designed to achieve specific health outcomes. Medi-Cal managed care plans will incorporate enhanced care management into their segmentation in accordance with DHCS enhanced care management target population guidance and Medi-Cal managed care plan flexibility afforded for the enhanced care management benefit. When risk stratifying its member population, Medi-Cal managed care plans must use a validated risk grouper.

Risk stratification or segmentation algorithms shall include past medical and behavioral health service utilization but must also incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. Medi-Cal managed care plans must analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, functional status, or other sources of health disparities. In the population health management program description, the Medi-Cal managed care plan will submit to DHCS its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is proprietary), and also the method of bias analysis. To promote transparency and best practices, these three pieces of information will be made available for public viewing on DHCS' website and will also be a focus of continuing Medi-Cal managed care plan learning collaborative activities.

Based on the risk stratification/segmentation and the findings from Individual Risk Assessment (IRA) described below, the Medi-Cal managed care plan will link the member with the appropriate services including, but not limited to, wellness and prevention, general case management, complex case management, enhanced care management, in lieu of services (as available) external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below.

DHCS Risk Tiering Requirements. This risk tiering process, including the IRA described below, will satisfy federal Medicaid Managed Care Final Rule requirements for initial risk assessment. Medi-Cal managed care plans will use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. The criteria for these tiers will be developed by DHCS.

The types of criteria used will be similar (but not the same) as the DHCS criteria for risk stratifying seniors and persons with disabilities (SPDs) into low- and high-risk groups. The criteria will align with the questions that DHCS will develop for the IRA survey tool, which is addressed in the next section. “High risk” members are those who are at increased risk of having an adverse health outcome or worsening of their health status. “Medium and rising risk” members are those that are stable at a medium risk level and those whose health status suggest they have the potential to move into the high-risk category.

Members at the medium/rising and high risk levels likely require additional provider-level assessment, care coordination, and/or possibly case management, or other specific services, which will be determined by the Medi-Cal managed care plan’s population segmentation strategy and coordination with providers. “Low risk” members are those who, in general, only require support for wellness and prevention. “Unknown risk” members are those who do not have sufficient data to stratify into a risk tier and for whom the Medi-Cal managed care plan is unable to complete a member-contact screening risk assessment. The IRA survey tool will be designed to have enough information to allow for risk tier assignment on its own if there is insufficient available historical data for the member.

DHCS will develop a process to validate Medi-Cal managed care plans’ implementation of the DHCS risk tier criteria to ensure consistent application and output statewide.

3. Individual Risk Assessment Survey Tool

DHCS will develop a standardized, 10-15 question Individual Risk Assessment (IRA) Survey Tool. There will be two versions, one for children and one for adults. Medi-Cal managed care plans will use the IRA to: (1) confirm or revise the initial DHCS risk tier to which the member was assigned; (2) gather consistent information for members without sufficient data; and (3) add information that will be used as part of its own stratification/segmentation algorithms and population health management strategy.

DHCS' goal in the development of the IRA questions will be to ensure they are validated and can be used with a scoring mechanism so that the IRA information can be integrated into the Medi-Cal managed care plan's risk stratification/segmentation process. DHCS will translate the questions into the threshold languages. Medi-Cal managed care plans will have the flexibility to add questions of their choosing to the IRA and would then also translate those additional questions into all threshold languages. It is expected that Medi-Cal managed care plans will conduct subsequent and separate screenings (or add supplemental questions) to identify specific issues and priorities to address.

The IRA will replace the assessments below:

- Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
- Health information form/member evaluation tool (HIF/MET)
- Health risk stratification and assessment survey for SPDs
- Whole Child Model Assessment
- The Initial Health Assessment (IHA) provider visit (within 120 days of enrollment) will remain a requirement, but DHCS contracts and policies will not specify provider requirements for that visit.

Medi-Cal managed care plans will continue to be required to ensure the provision of preventive and other services in accordance with contractual requirements and accepted standards of clinical care.

Members assigned to the DHCS medium/rising, high, and unknown risk tiers must be contacted within 90 (medium/rising) and 45 (high and unknown) calendar days respectively to assess their needs. The IRA may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. Data exchange of IRA elements with DHCS is not required at this time. Medi-Cal managed care plans should use this modality flexibility to maximize successful contact. Medi-Cal managed care plans shall make at least three (3) attempts to contact a member using available modalities.

If the Medi-Cal managed care plan is unable to obtain a completed IRA from a member, it has the option to create a process for working with the member's assigned primary care provider to: 1) have the member complete the assessment with them; and 2) transfer the resulting information to the Medi-Cal managed care plan.

Medi-Cal managed care plans will use the IRA information to assign or revise the member's DHCS risk tier. Once that process is complete, Medi-Cal managed care plans will be responsible for reporting the member's assigned risk tier to DHCS in an electronic format to enable better tracking and assessment of the impacts of the population health

management program. The Medi-Cal managed care plan will also share information regarding the assigned member's risk tier to the member's assigned PCP in an electronic format. If the member transfers to another Medi-Cal managed care plan, DHCS will provide the member's risk tier to the new Medi-Cal managed care plan.

The IRA questions will align with the DHCS-specified criteria for high, medium/rising, and low risk tiers. It is DHCS's intent that the structure of the IRA will meet NCQA requirements for a Health Appraisal.

- The IRA will include 10-15 questions, which seek to identify preliminary risk information for the following elements: Behavioral, developmental, physical, Long Term Services and Supports, and oral health needs;
- Emergency department visits within the last six months;
- Self-assessment of health status and functional limitations;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Desire or need for case management;
- Ability to function independently and address his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for long-term services and supports;
- Availability of social supports and caregiver;
- Access to private and public transportation;
- Social and geographic isolation; and
- Housing and housing instability assessment;

4. Reassessment

At a minimum, the Medi-Cal managed care plan shall reassess risk and need, including rising risk, of all members annually both the DCHS risk tiering and its own risk stratification/segmentation process. Individual members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what events or data trigger the re-evaluation process for individual members. In the population health management program description, the Medi-Cal managed care plan must inform DHCS what minimum risk groups would require regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as required by DHCS.

5. Provider Referrals

Medi-Cal managed care plans must establish a process by which providers may make referrals for members to receive case management or services for other emerging needs. Referrals for case management should lead to a re-evaluation of risk stratification and DHCS risk tier assignment. Medi-Cal managed care plans must consider and integrate information received through referrals when determining members' risk stratification.

Actions to Support Wellness and Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate including, but not limited to member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals, developmental services referrals, dental referrals, referrals to home-based medical/social services for people with serious illness, and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24-hours-a-day, 7-days-a-week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The Medi-Cal managed care plan shall provide wellness and prevention services in accordance with NCQA and contractual requirements. The population health management program shall integrate wellness and prevention services for all members, regardless of risk tier, according to the benefits outlined in the managed care contract including, but not limited to, the following:

- Provide preventive health visits, developmental screenings, and services for:
  - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
  - All adults in accordance with US Preventive Services Task Force Grade "A" and "B" recommendations.
- Monitor the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Medium/Rising Risks

The population health management program shall:

- Provide screening for Adverse Childhood Experiences (ACEs) for children and adults, based on the recommended periodicity schedule as specified in the Medi-Cal managed care contract.
- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs including preventive care, care for chronic conditions, and referrals to long-term services and supports, as appropriate;

- Refer members identified, through assessment or re-assessment, as needing care coordination or case management to the member's case manager for follow-up care and needed services within 30 calendar days; and

- Assess individual social care needs and deploy appropriate community resources and strategies to mitigate the adverse childhood experiences (ACEs) toxic stress and impacts of social determinants of health in partnership with providers and community organizations.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports. To address this focus, Medi-Cal managed care plans shall incorporate the DHCS Population Needs Assessment and NCQA Population Health program requirements on this topic into their population health management strategy. Identifying and addressing the needs of specific high-risk communities and populations – sometimes referred to as "hot spotting" – will be a focus of the population health management learning collaborative and DHCS will continue to assess best practices in this area.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems and acquiring self-care skills to improve functioning and health outcomes, slow the progression of disease or disability or prepare for the progression of a serious illness. Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services. Members determined to be low risk should continue to receive wellness and prevention services as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Screening beyond the IRA to identify and prioritize goals and needs for case management, including both health issues, ACEs and toxic stress, and health-related social needs
- Documentation in an electronic format of the individual care plan and assigned case manager for each member (required for all case management).
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member's goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact for the member.

- Access to person-centered planning, including advanced care planning regarding preferences for medical treatment, and education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, and developmental and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement interventions that address social determinants of health (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, palliative care, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.
- Requesting modifications to treatment plans to address unmet service needs that limit progress.
- Assisting members in relapse and/or crisis prevention planning that includes development and incorporation of recovery action plans, and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Assisting members in care planning related to cognitive impairment, traumatic brain injury, Alzheimer's disease, and dementia.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting case management requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.

Members may be assigned to one of three types of case management based on assessment of risk and need.

The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include assignment to a certified patient-centered medical home, participation in a Medi-Cal managed care plan disease management program or participation in another Medi-Cal managed care plan population health management program.

- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as "a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources." NCQA allows organizations to define "complex." Complex case management generally involves the coordination of services for high-risk members with complex conditions.

- **Enhanced Care Management:** The proposed Enhanced Care Management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The population health management program description shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA's population health management delegation requirements.

5. In Lieu of Services

"In lieu of services" are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management programs. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, the Health Homes Program, the Coordinated Care Initiative, etc.), as well as inform the development of future potential statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot program that are not covered as Medi-Cal State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically tailored meals, supplemental personal care services, housing tenancy navigation and sustaining services, and sobering centers. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types of services. See **Appendix J: In Lieu of Services Options** for more detail.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The Medi-Cal managed care plan must coordinate with competent external entities to provide all necessary services and resources to the member. These entities should be listed as part of the population health management program description identifying specific services each named entity will provide plan members. The Medi-Cal managed care plan's population health management

program description shall include assurance of payment to Indian Health Care Providers.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The Medi-Cal managed care plan shall work with appropriate staff at any hospital that provides services to its members, whether contracted or non-contracted in the case of emergency services, to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission.

The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing network arrangements with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions. Transition services shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall assess risk for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;
- Process all hospital prior authorization requests for clinic services within two business days. Such services shall include authorizations for therapy, home care services, equipment, medical supplies, and pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services that require pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes, but is not limited to, prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services, and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional service requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;
- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and

- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would need to be reviewed and approved by the state.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care, and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making, and case management. An overarching goal of the population health management program is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value-based payment models, and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans, and advance directives necessary to coordinate service delivery and care management for each member in accordance with applicable privacy laws.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal managed care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans to include changes

to its audit procedures and the imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that, through this and the other CalAIM proposals, the responsibility of Medi-Cal managed care plans will increase over time, and therefore DHCS' approach to oversight and accountability must also grow and change in conjunction with these proposals. DHCS is committed to providing Medi-Cal managed care plans technical assistance to support the smooth adoption of these changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plans in development of their population health management programs, DHCS will provide submission templates and best practice examples of Medi-Cal managed care plan population health management programs from California and other states. DHCS will also create a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. The learning collaborative will foster information sharing and address promising practices in all the DHCS-required population health management activities. The following topics that have been identified by stakeholders:

- Medi-Cal managed care plan coordination and partnerships with external entities that provide carved-out services, such as specialty mental health, Drug Medi-Cal, Regional Centers, schools, public health departments, and community-based organizations that provide social services;
- Engaging with consumers who have health and social needs but are unidentified, unengaged, and are underutilizing services, including methods to engage with these members, build trust, and obtain information from the member about their needs;
- Care transition coordination including sharing discharge risk assessment tools;
- Incorporating social determinants of health and health-related social care needs into case management and community-level population improvement activities;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes;
- Best practices in how to use population health management programs to support specific populations of interest, such as children and pregnant women, in ways that align with other DHCS initiatives;
- Use of population data for "hot spotting" and other population analysis promising practices;

- Use of general beneficiary medical record release consent to allow Medi-Cal managed care plans and providers to share data broadly for the purposes of care coordination;
- Learning best practices from California Accountable Communities for Health Initiative activities, including opportunities for partnership and elements that may be appropriate to integrate into the population health management strategies;
- Data exchange protocols and the development of health information technology/health information exchange policies; and
- Submission of housing status data to DHCS via ICD-10 coding, in alignment with the current DHCS Value-Based Payment incentive program for these codes.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan outcomes. DHCS may also standardize certain requirements after further research and consultation with stakeholders.

Continuing areas of DHCS policy development will include:

- DHCS Risk Tiering criteria;
- DHCS IRA to gather individual member information for risk tiering and stratification;
- Detailed review of alignment with NCQA Population Health program requirements, in coordination with NCQA and Medi-Cal managed care plans;
- Continued exploration into what guidance DHCS can provide regarding what can be allowed for different types of information sharing between providers and Medi-Cal managed care plans to facilitate care coordination;
- Voluntary guidance from DHCS regarding Medi-Cal managed care plan collection of social determinants of health data from ICD-10 encounter coding. The guidance, and Medi-Cal managed care plan collection of this data in accordance with the guidance, will become mandatory on January 1, 2024; and
- Setting prospective, prioritized goals to improve Medi-Cal managed care population health management over five years from the implementation date. To do this, DHCS will review of population health management program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan's population health management program.

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other CalAIM proposals to meet the overarching CalAIM goals of improving coordination and quality, while reducing unnecessary administrative burden and redundancy. The following CalAIM elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** will provide a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **enhanced care management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **in lieu of services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within the population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers will maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2023. The date for the first population health management program description submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.

2.2 Enhanced Care Management Benefit

2.2.1 Background

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.). Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence.

Additionally, as one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. The Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management benefit within Medi-Cal managed care. Lessons learned from the Whole Person Care pilots and the Health Homes Program will be incorporated to ensure that the new enhanced care management benefit is designed to meet the clinical and non-clinical needs for the highest cost/highest need beneficiaries in Medi-Cal and is available as a statewide benefit.

2.2.2 Proposal

The proposed enhanced care management benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots, building on positive outcomes from those programs over the past several years. Based on extensive stakeholder engagement, DHCS will require that beneficiaries receiving Health Homes or Whole Person Care services are seamlessly transitioned to continue receiving care coordination services by way of the new enhanced care management benefit. Medi-Cal managed care plans will be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with a few contractual exceptions. Medi-Cal managed care plans will be required to contract with community-based providers that have experience serving the enhanced care management target populations, and who have expertise providing the core enhanced care management services. Further, to allow non-Whole Person Care or Health Homes Program counties additional time to develop an adequate local infrastructure, a phased-in approach for implementing enhanced care management will be adopted.

It is the state's intention to implement this new initiative in a complementary, rather than duplicative manner that will build upon the strengths and foundations of these existing programs. DHCS recognizes the significant investment the Whole Person Care entities made over the past five years in building the capacity for these services. The intention is to build on those investments and infrastructure to continue the positive outcomes achieved by the Whole Person Care pilots. Additionally, as a result of extensive stakeholder feedback, DHCS has determined that Medi-Cal managed care plans will be required to coordinate enhanced care management services with county Targeted Case Management programs to ensure non-duplication of services and provide a holistic approach to care for Medi-Cal's most vulnerable beneficiaries.

The proposed enhanced care management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to

providing intensive and comprehensive care management services to targeted individuals.

Medi-Cal managed care plans will proactively identify members who meet the target population criteria and can benefit from enhanced care management services. The enhanced care management providers will be taking on the responsibility for coordinating services across all delivery systems. They are the primary responsible entity for coordinating across multiple medical and social service domains of care. Authorized members will be assigned a lead care manager that will have responsibility for interacting directly with the member and coordinating all primary, behavioral, developmental, oral health, and long-term services and supports, any in lieu of services, and services that address social determinants of health needs, regardless of setting.

Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The overarching goals for enhanced care management are:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes;
- Addressing social determinants of health; and
- Decreasing inappropriate utilization.

The enhanced care management target populations include: (see **Appendix I: Enhanced Care Management Target Population Descriptions** for more detailed definitions):

- Children or youth with complex physical, behavioral, developmental, and/or oral health needs (e.g. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

Enhanced Care Management Design and Services

The enhanced care management benefit, which will be delivered by community-based providers (”ECM Providers”) contracting with Medi-Cal managed care plans, will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for indirect care needs.

The enhanced care management benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. Enhanced care management will emphasize prevention, health promotion, continuity and coordination of care to link members to services as necessary across providers and settings and with emphasis on identifying the least restrictive and most integrated setting that will meet the needs of the beneficiary.

The role of enhanced care management is, through face-to-face visits, to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. Enhanced care management activities shall become integrated with other care coordination processes and functions and shall assume primary responsibility for coordination of the member’s physical health, behavioral health, oral health, developmental, and long-term care needs.

Enhanced care management will be provided at a level dictated by the complexity of the health and social needs of the member. The approach to enhanced care management will be high-touch, on-the-ground, and face-to-face, with frequent contacts for persons residing in community settings and nursing facilities. Enhanced care management care managers are expected to develop relationships with members and their families, engage

members and families in needs assessment and care planning processes, and work with the primary care provider to address the member's needs in coordinating physical and behavioral health care.

The enhanced care management care managers will operate within the member's community, serve as the members' primary point of contact and are responsible for ensuring that applicable physical, behavioral, long-term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs. Care managers meet members where they are, both literally, and from a medical management and plan of care perspective. Community health workers can also be used to improve outreach and provide care coordination services for beneficiaries.

Required programmatic elements to be implemented include, but are not limited to, care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services. These elements include helping beneficiaries navigate, connect to and communicate with providers and social service systems; coaching beneficiaries on how to monitor their health and identify and access helpful resources; identifying and coordinating available in lieu of services such as housing services; helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions; educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; providing referrals to community and social services; and follow-up to help ensure that beneficiaries are connected to the services they need.

Program Administration

Enhanced care management will be administered by the Medi-Cal managed care plans, who will have direct responsibility for establishing the enhanced care management benefit and criteria for their members, subject to contractual requirements and programmatic guidance provided by DHCS. DHCS intends for Medi-Cal managed care plans to build upon the expertise and infrastructure of the existing Whole Person Care pilots and Health Homes Program to achieve these outcomes and, with some exceptions, to contract directly with existing Whole Person Care providers and Health Homes Program community-based care management entities, as well as other necessary contracting with public and private providers to deliver such services.

In addition, DHCS expects that plans will work in coordination and collaboration, and even contract when appropriate, with county behavioral health systems who often are the primary providers of services to a subset of Medi-Cal beneficiaries. This proposal requests that managed care plans determine the service design and intensity based on the parameters established by DHCS. DHCS will build enhanced funding into the

capitation rates to enable Medi-Cal managed care plans to successfully provide enhanced care management benefit. The Medi-Cal managed care plans will have strong oversight and will perform regular auditing and monitoring activities to ensure that all requirements are met. If a plan proposes to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the state that their enhanced care management benefit is appropriately community-based and provide a rationale for not contracting with existing WPC and HHP providers (per the exceptions outlined in the enhanced care management and in lieu of services Model of Care Template and managed care plan contract language.)

For individuals with a primary SMI diagnosis, SUD, children with SED, or children involved in child welfare, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, provided they agree to coordinate all the services (physical, developmental, oral health, long-term care and social needs) needed by those target populations, not just their behavioral health needs. These staff will focus on the behavioral health needs and interventions for the Medi-Cal beneficiary, act as a resource for the Medi-Cal managed care plan in managing the needs of this population and ensuring that beneficiaries are linked to appropriate county resources; as well as other resources that have more experience and documented success in working with those living with these conditions.

Targeted Case Management

Furthermore, Medi-Cal managed care plans will be expected to work with Local Governmental Agencies to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services; this approach will also help support the Department's goal of strengthening the connections across California's delivery systems. The Targeted Case Management program is an optional Medi-Cal Program funded by federal and local funds. See **Appendix B: Targeted Case Management** for which counties currently participate in the Targeted Case Management program.

DHCS may need to review and discuss other potential county funding interactions with this benefit to ensure there is no duplication of services or funding.

Transition and Coordination Plan

Medi-Cal managed care plans currently operating a Health Homes Program or operating in a county with a Whole Person Care pilot or Targeted Case Management program, will be required to submit a transition and coordination plan to DHCS by July 1, 2021. Through the transition and coordination plan, managed care plans will demonstrate how they will translate the existing programs into the enhanced care management benefit and in lieu of services and coordinate with existing Targeted Case Management programs. The

plans must also demonstrate a good faith effort to contract for enhanced care management and in lieu of services with existing Health Homes providers and Whole Person Care entities already providing such services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to a contractual agreement.

Medi-Cal managed care plans in counties with Targeted Case Management programs will be required to submit information in the transition and coordination plan describing how they will work with the Local Government Agency to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services.

A transition and coordination plan will not be required for Medi-Cal managed care plans in counties that do not have Whole Person Care pilots, Health Homes Programs, or Targeted Case Management.

Implementation

January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.

July 1, 2022:

- Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
- All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.

January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Medi-Cal managed care plans that begin implementing on January 1, 2022 will submit an enhanced care management Model of Care proposal to DHCS for review by July 1, 2021. Draft contract provisions will be shared with plans in February 2021. Medi-Cal managed care plans that will implement enhanced care management on July 1, 2022, will submit an enhanced care management Model of Care by January 1, 2022. All plans must complete readiness activities for the mandatory target populations. Medi-Cal managed

care plans can submit to DHCS additional optional target populations, in addition to the mandatory target populations.

Federal regulations require that Medi-Cal managed care plan implementation activities shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. Through the enhanced care management Model of Care, managed care plans must demonstrate that there are sufficient Indian Health Clinics participating in their provider network to ensure timely access to services available under the contract from such providers for American Indian enrollees who are eligible to receive services. Medi-Cal managed care plans will provide a description of their coordination with tribal partners within the enhanced care management transition and coordination plan.

By July 1, 2022, all Medi-Cal managed care plans will need to submit to DHCS an enhanced care management Model of Care proposal for serving individuals transitioning from incarceration for implementation on January 1, 2023 in all counties. Re-entry transitions involve working closely with corrections departments, including probation, courts and the local county jail system to ensure connections to care once individuals are released from jail. While there is some infrastructure in place for this enhanced care management target population due to Whole Person Care Pilots, these types of arrangements require significant planning and coordination between the managed care plan, counties, sheriff, probation, and other key stakeholders.

DHCS is also looking to leverage the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act provisions that may make it possible to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release.

This aspect of enhanced care management will support the scaling of diversion efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities. In this case, Medi-Cal managed care plans can contract with county and non-profit entities that work to meet the health care needs of those who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan built to avoid incarceration and get into community-based care and services.

Furthermore, to complement this enhanced care management benefit, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023.

Mandated County Inmate Pre-Release Application Process

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director letter, entitled "Ending Chronic Homelessness," that encouraged states to ensure that applications for Medicaid are processed in a timely manner so that individuals can receive Medicaid-covered services immediately upon release from a public institution.

On May 6, 2014, DHCS provided guidance in All-County Welfare Directors Letter #14-24, on the pre-release application process for state inmates who apply for Medi-Cal coverage. Subsequently, on June 25, 2014, DHCS clarified in All County Welfare Directors Letter #14-24E, that the guidance issued in the May 2014 letter is also applicable to county inmates. However, a specific pre-release process to facilitate the applications for county inmates was not defined and implementation of such process was voluntary.

The current pre-release application process varies from county to county. From a survey of some counties, DHCS learned that relatively larger counties with pre-release programs, such as Orange County and Stanislaus County, have agreements with third-party entities (e.g., community-based organizations or vendors) to streamline the pre-release application process and to provide dedicated application intake staff that visit individuals at the county jail while still in custody. Of the smaller counties surveyed, Yolo County has an agreement with the Sheriff's Department to establish communication channels and set up physical stations at the correctional facility, as well as security clearances for designated county staff to speak with the county inmate applicant directly. **Appendix C: County Inmate Pre-Release Application Process sample contracting Models** includes the three main models currently being used for various county inmate pre-release application programs.

DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include juvenile facilities. The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.

Additionally, DHCS is proposing to mandate that all county jails and juvenile facilities implement a process for facilitated referral and linkage from county release to county specialty mental health, Drug Medi-Cal, Drug Medi-Cal Organized Delivery Systems, and Medi-Cal managed care providers when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. DHCS will look to counties to implement medical record release processes that would allow medical records to be shared with the county behavioral health and Medi-Cal managed care providers, prior to or upon release from jail or county juvenile facility.

The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration will ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.

2.2.3 Rationale

DHCS continues to strengthen integration within the state's health care delivery system and is working with health promotion partners to achieve better care and better health outcomes at lower cost to the Medi-Cal program. Creating a statewide enhanced care management benefit with required target populations is consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels. Targeted individuals are beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, chronic illnesses, disabilities, multiple social determinants of health, and require multidisciplinary care to regain health and function.

The enhanced care management benefit will provide Medi-Cal managed care plans with opportunities to help beneficiaries achieve improved health and well-being through stratifying risk and need and developing care plans and strategic interventions. Enhanced care management services will extend beyond standard care coordination and disease management activities. They will be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

2.2.4 Proposed Timeline

DHCS is proposing a phased statewide implementation of the enhanced care management benefit and inclusion in Medi-Cal managed care contracts. Medi-Cal managed care plans in counties with Whole Person Care Pilots and/or Health Homes Programs will implement enhanced care management on January 1, 2022 for those target populations currently receiving Health Homes and/or Whole Person Care services. On July 1, 2022, Medi-Cal managed care plans in those counties will implement additional required target populations and counties without Whole Person Care pilots and/or Health Homes Programs will begin implementing select populations on July 1, 2022. The benefit must be implemented for in all counties all target populations, including individuals transitioning from incarceration, by January 1, 2023.

DHCS is proposing an effective date of January 1, 2023 for counties to implement a county inmate/juvenile pre-release application process. To ensure the necessary data

sharing agreements and communication plans are in place, below is detailed timeline for planning and implementation of this proposal:

- **March 1, 2021:** Establish workgroup with County Welfare Director's Association and counties to develop and vet implementation plan
- **May 1, 2021:** All county guidance development
- **November 1, 2021:** County and stakeholder feedback process
- **January 1, 2022:** Publish All County Welfare Director Letter
- **January – December 2022:** County implementation planning and technical assistance
- **January 1, 2023:** Implementation of county inmate pre-release application process

2.3 In Lieu of Services

2.3.1 Background

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. The implementation of these programs, however, has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An in lieu of service can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the in lieu of service; and
- The in lieu of services are authorized and identified in the state's Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care

management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs to avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use. Based on extensive stakeholder feedback, DHCS has updated the in lieu of services menu of services. The feedback enhanced the overall design of in lieu of services, allowing beneficiaries receiving Health Homes or Whole Person Care services to continue receiving optional plan services. Furthermore, the additional feedback optimized the depth and capacity for serving eligible beneficiaries.

2.3.2 Proposal

DHCS is proposing to include the following fourteen (14) distinct services as in lieu of services under Medi-Cal managed care. Details regarding each proposed set of services are provided in **Appendix J: In Lieu of Services Options**:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for Medi-Cal managed care plans and beneficiaries have the option to accept the in lieu of services or receive the State Plan services instead. Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations. However, individual in lieu of services may be used

together with other complementary in lieu of services based on individual needs and may be combined with enhanced care management services for high-risk, complex-need individuals. ILOS can be offered as an appropriate EPSDT service. Other appropriate EPSDT services should be offered in conjunction with any ILOS.

Transition and Coordination Plan

Since DHCS is building on the infrastructure developed for the Health Homes Program and parts of the Whole Person Care pilots, Medi-Cal managed care plans in counties with these programs will be required to submit a Transition and Coordination Plan to the state by July 1, 2021 demonstrating how they will transition existing programs into their enhanced care management benefit and in lieu of services. The plans must also demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services with Health Homes providers and Whole Person Care entities providing such services. DHCS recognizes the significant investment in infrastructure, as well as the existing expertise in providing these types of services, by our local county and other public/private partners and expects Medi-Cal managed care plans to partner with these entities to continue providing these critical services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS a justification as to why the plan has not contracted with such entities.

2.3.3 Rationale

Adoption of this set of in lieu of services will provide additional support to beneficiaries with complex medical and behavioral health needs who experience socio-economic conditions that impede their ability to achieve their health goals. These circumstances put them at risk of hospitalization, institutionalization, and/or in need of other higher cost services.

Currently, Medi-Cal strategies to address beneficiaries' social determinants of health vary across the state, depending on the initiatives underway in different regions. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of in lieu of services will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. This may include partnerships to develop physical infrastructure, as well as collaborations with new provider types who have not historically worked with Medi-Cal. This will also set the stage for Medi-Cal managed care

plans to be prepared to have long-term services and supports integrated into their care program by 2027.

The stakeholder feedback was critical to ensuring that the identified services will adequately address the critical needs of beneficiaries. The final policy incorporates feedback received regarding strategies for building the necessary service infrastructure in a cost-effective manner, finalizing the eligible populations, potential restrictions and limitations, and appropriate provider types to deliver this new set of services.

2.3.4 Proposed Timeline

January 1, 2022: DHCS is proposing statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts. DHCS will provide technical assistance to plans as they prepare to implement this new set of services.

2.4 Shared Risk, Shared Savings, and Incentive Payments

2.4.1 Background

The combination of carving in long-term care statewide, enhanced care management and in lieu of services provides a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program by 2027 and building the necessary clinically-linked housing continuum for our homeless population.

In order for the state to be equipped with the needed MLTSS and clinically linked housing continuum infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. Incentive funding will be focused on building a pathway for Medi-Cal managed care plans to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable enhanced care management and in lieu of services capacity, and achieve improvements in quality performance that can inform future policy.

2.4.2 Proposal

DHCS proposes to create a series of incentives through a multi-pronged risk strategy. Potential approaches include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care. The rate will be subject to a blend true-up, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.

- A time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS. This tiered model would be available for three calendar years – 2023, 2024 and 2025.

- A prospective model of shared savings/risk incorporated via capitation rate development. DHCS proposes to implement this approach beginning in calendar year 2026, once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.

DHCS will establish plan incentives linked to delivery system reform through an investment in enhanced care management and in lieu of services infrastructure. The incentive payments will also be based on quality and performance improvements and reporting in areas such as LTSS and other cross-delivery system metrics. The target of incentive payments is to drive change at the managed care plan and provider levels. DHCS anticipates managed care plans will partner and share the incentive dollars with on-the-ground providers, including our critical partners that operate Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers to work collaboratively to meet the defined targets of incentive program.

2.4.3 Rationale

In recognition of the financial uncertainties that accompany the implementation of enhanced care management, in lieu of services, and MLTSS statewide, DHCS is committed to implementing strategies that will limit excessive financial risk (losses) for Medi-Cal managed care plans, as well as for the state and federal governments. At the same time, DHCS supports the use of strategies that will result in financial gains that can be shared between Medi-Cal managed care plans and the state and federal governments. DHCS' goal is to establish financial mechanisms that will ensure a mutual commitment to the success of the proposed short- and long-term reforms and innovations within the Medi-Cal managed care program.

DHCS' proposed risk approaches are intended to strengthen financial incentives for Medi-Cal managed care plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;

- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program; and

- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

2.4.4 Proposed Timeline

Rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with Medi-Cal managed care plans and make future refinements as determined appropriate.

- **January – December 2021:** Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Begin implementation of managed care plan incentives.
- **No sooner than January 1, 2023:** Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

2.5 Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity

2.5.1 Background

On November 13, 2018, CMS issued a State Medicaid Director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) who are enrolled in Medicaid.

This SMI/SED demonstration opportunity allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD) (e.g., psychiatric hospitals or psychiatric health facilities that have more than 16 beds), as long as it is part of a broader effort to build a robust continuum of care allowing care in the least restrictive, community-based settings. Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings.

2.5.2 Proposal

DHCS proposes that California pursue this SMI/SED demonstration opportunity to receive federal financial participation for services provided to Medi-Cal beneficiaries in an IMD. DHCS heard from stakeholders both positive and negative feedback regarding this proposal. Stakeholders in favor of the demonstration opportunity stated the additional federal funds could provide opportunities to improve service delivery and outcomes

across the continuum of care from inpatient to community-based settings, and the availability of additional matching funds would free up other local resources that counties could reinvest in strengthening other mental health services and further build the continuum of care in the community.

Proponents suggested that the demonstration opportunity is a critical component of solutions for the state hospital crisis (with long wait lists for people found incompetent to stand trial, as the state hospitals are full) and for achieving health equity, since increasing the number of short-term, crisis stabilization resources can divert people with mental illness to treatment instead of entering the justice system. People of color are disproportionately placed in justice settings instead of in mental health treatment, and lack of bed availability is a contributing factor. Stakeholders also expressed opposition based on concerns that the presence of the existing IMD exclusion is the primary safeguard in inhibiting county mental health departments from expanding the use of institutional settings and an important incentive to develop alternatives to those settings, and that using federal dollars to fund IMDs could divert resources from community-based services, undermining progress toward increased community integration and a community-based continuum of care.

On balance, DHCS believes the benefits outweigh the risks, and proposes that California submit an application to CMS using the usual process for submitting a Section 1115 waiver demonstration application. Similar to the state's existing 1115 demonstration to provide residential and other SUD treatment services under Medi-Cal, county participation would be voluntary.

2.5.3 Rationale

If California is approved to participate in the SMI/SED demonstration opportunity, federal financial participation would become available for mental health services provided to Medi-Cal beneficiaries in an IMD if all requirements are met. This additional funding would provide opportunities to improve service delivery and outcomes across a well-developed and robust continuum of care from inpatient to community-based settings, which is a requirement of this waiver. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.

The SMI/SED demonstration opportunity comes with many federal milestones and requirements. As of October 2020, Washington DC, Vermont, Indiana, and Idaho have approved applications, and Massachusetts, Oklahoma and Utah have pending 1115 waiver application to CMS. Below is a summary of key requirements, some of which may pose feasibility challenges:

- **Average Length of Stay:** The state would be required to achieve a statewide average length of stay of no more than 30 days for beneficiaries residing in IMDs. CMS developed guidance regarding calculations of average length of stay, clarifying that a short-term stay for acute care is limited to no more than 60 consecutive days, as long as the state continues to meet the statewide average length of stay of 30 days or less, and that states may not claim for *any* part of a stay (days 0 to 60) that exceeds 60 days.

- **Improving Community-based Services**: States participating in the SMI/SED demonstration opportunity will be expected to commit to taking several actions to improve community-based mental health care. These actions are linked to a set of goals for the SMI/SED demonstration opportunity and will milestones for ensuring quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI/SED in treatment as soon as possible.

- **Maintenance of Effort:** According to the guidance, CMS will be examining the commitment to ongoing maintenance-of-effort on funding outpatient community-based mental health services and states must provide an assessment of current availability of mental health services. The purpose of the maintenance-of-effort requirement is to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

- **Data Collection & Required Measures:** The state would need to report on a common set of measures and agree to additional measures and concepts specific to the state's demonstration parameters.

- **Health Information Technology:** The state would be required to develop and submit a health information technology plan that describes the ability to leverage technology, advance health information exchange(s), and ensure interoperability in support of the demonstration's goals. The health information technology plan would address electronic care plan sharing, care coordination, and behavioral and physical health integration.

- **Staffing and Resource Considerations:** Since DHCS does not currently pay for IMD services for this target population, pursuing the demonstration and ensuring compliance with requirements would require additional staffing and resources. Similarly, counties would likely need additional resources to implement and comply with elements required by the demonstration.

For additional information about the demonstration goals and milestones, federal application requirements, and other relevant requirements, please refer to the **Appendix E: CalAIM Benefit Changes Chart** of this proposal.

2.5.4 Proposed Timeline

The SMI/SED demonstration proposal would be developed no sooner than July 1, 2022. If the waiver proposal is approved by CMS, DHCS would work with interested counties to develop a formal implementation plan, with expected launch of the demonstration in 2023-24.

2.6 Full Integration Plans

2.6.1 Background

Currently, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems to meet all of their health care needs. Beneficiaries enrolled in Medi-Cal managed care plans receive physical health care and treatment for mild-to-moderate mental health conditions from their Medi-Cal managed care plan, care for SMI/SED and SUD from the county delivery system, and dental care from a separate fee-for-service delivery system or a dental managed care plan. This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries. The longevity gap among individuals with serious and persistent mental illness, and the fact that this group suffers and dies from un-or under-treated chronic physical health conditions, demonstrates the need to pilot the concept of a fully integration delivery system.

2.6.2 Proposal

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and DMC-ODS programs) would be consolidated under one contract with DHCS. To further develop this concept, DHCS will be engaging in stakeholder conversations to inform the development of the various components associated with fully integrating health care services. Topics will include contractor selection criteria, strategies for consolidating contract requirements, subcontracting and network requirements, and delivery system administration issues such as care coordination, utilization management, quality monitoring, and external quality review organization functions.

2.6.3 Rationale

In alignment with CalAIM, fully integrating all or most of the Medi-Cal health care delivery systems under one contract would improve the beneficiary experience as well as health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems. In addition, integration will improve access to health data/data sharing among providers and between the plan and DHCS. Full integration would also result in overall administrative simplification by consolidating and streamlining system infrastructure. An integrated delivery system would allow for more efficient coordination of care and create opportunities to identify and manage the risks and needs of the beneficiaries in a more holistic way.

As part of the CalAIM workgroup process, DHCS sought stakeholder feedback to understand the benefits, risks and considerations for plans and counties interested in participating in a full integration model. Discussion included realignment (county behavioral health participation would need to be voluntary), how non-Medi-Cal funding streams would be managed (such as MHSA), criteria for participation, the need for adequate planning and preparation, the importance of clearly defined outcome measures, and other considerations.

2.6.4 Proposed Timeline

DHCS acknowledges the complexity of this proposal, and for this reason, is proposing a go-live of no sooner than January 2027, to allow sufficient time for planning and preparation, in partnership with counties, plans and other stakeholders.

2.7 Long-Term Plan for Foster Care

2.7.1 Background

Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences (ACEs) Navigating multiple systems of care can create inherent challenges. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, dental county mental health plans, Drug Medi-Cal, and DMC-ODS programs. While children and youth in foster care typically have a comprehensive team to help facilitate and oversee their care including social workers, public health nurses, and the judicial system; many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county.

In recent years, California has placed a greater emphasis on the behavioral health care needs of child welfare-involved children and families through major reforms such as the

Continuum of Care Reform, Family Urgent Response System, development of short-term residential treatment providers and coordinated efforts to implement the new federal Family First Prevention Services Act in California.

2.7.2 Proposal

In assessing the challenges foster care children and youth face, in June 2020 DHCS launched a workgroup of interested stakeholders to consider whether DHCS should develop a different model of care for children and youth in foster care, including the former foster youth and youth transitioning out of foster programs and services. To facilitate this discussion and develop meaningful recommendations, DHCS invited participation from key partners including but not limited to: the Department of Social Services, the Department of Education, child welfare county representatives and state-level associations, Medi-Cal managed care plans, behavioral health managed care plans, juvenile justice and probation, foster care consumer advocates, regional centers, and judicial entities involved with matters pertaining to children who are placed into the foster care system. DHCS also commissioned focus groups with foster youth and foster parents, to hear directly from those most affected by the challenges in the current system.

2.7.3 Proposed Timeline

DHCS launched the workgroup in June 2020, and will meet every other month through June 2021. DHCS and CDSS then will take lessons learned from the workgroup and the input from stakeholders and develop a comprehensive set of recommendations and plan of action, which may involve budget recommendations, waiver amendments, State Plan changes or other activities.

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

This section will walk through the proposals aimed at standardizing and reducing complexity across all delivery systems.

Managed Care

- Managed Care Benefit Standardization
- Mandatory Managed Care Enrollment
- Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Managed Care Capitation Rates

Behavioral Health

- Behavioral Health Payment Reform
- Medical Necessity Criteria and Other Related Changes
- Administrative Integration of Specialty Mental Health and Substance Use Disorder Services
- Behavioral Health Regional Contracting
- DMC-ODS Renewal and Policy Improvements

Dental

- New Dental Benefits and Pay for Performance

County Partners

- Enhancing County Eligibility Oversight and Monitoring
- Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention
- Improving Beneficiary Contact and Demographic Information

Managed Care

3.1 Managed Care Benefit Standardization

3.1.1 Background

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental health, Drug Medi-Cal Organized Delivery System, and Drug Medi-Cal. Most full-scope Medi-Cal beneficiaries receive their physical health

services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

3.1.2 Proposal

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

DHCS is proposing the following changes:

Carved Out Benefits

- Effective April 1, 2021, all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from Medi-Cal managed care plans (pursuant to the Governor's Executive Order N-01-19 from January 7, 2019). This applies to all Medi-Cal managed care plans, including AIDS Healthcare Foundation, but does not apply to SCAN Health Plan, Programs of All-Inclusive Care for the Elderly (PACE) organizations, Cal MediConnect health plans, and Major Risk Medical Insurance Program (MRMIP).

- Effective January 1, 2022, the following benefits that are currently within the scope of some or all the Medi-Cal managed care plans will be carved out:

    - Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties; and

    - The Multipurpose Senior Services Program which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.

Carved In Benefits

- Effective January 1, 2022, all major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

- Effective January 1, 2023, institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities), currently

not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long-term care and transplant providers accept as payment in full and require the Medi-Cal managed care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan mutually agree upon an alternative payment. This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

3.1.3 Rationale

The standardization of benefits delivered through Medi-Cal managed care plans statewide has two main purposes and benefits:

- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they need to access another delivery system; and
- DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.1.4 Proposed Timeline

The benefit standardization will be effective and included in Medi-Cal managed care plan contracts by January 2023, according to **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage**.

3.2 Mandatory Managed Care Enrollment

3.2.1 Background

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

3.2.2 Proposal

In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system, would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service. DHCS completed extensive data analytics to inform this proposal, for example, 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-long-term care share of cost beneficiaries, on average only 5.4% of beneficiaries meet their monthly share of cost.

DHCS is proposing implementation of this change in two phases, transitioning non-dual eligible populations in 2022 and dual eligible populations in 2023. A non-dual member is defined as a Medi-Cal member without any Medicare coverage. A dual beneficiary is defined as a Medi-Cal member with any Medicare coverage. This would include Medi-Cal members with Medicare A only or Part B only (partial duals) and members with Medicare Part A and B (full duals) regardless of enrollment in Medicare Part C or Part D. See below for a summary of changes and **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage** for more details.

Given the ability and directive of Medi-Cal managed care plans to provide case and care management not available in a fee-for-service environment, DHCS firmly believes that Medi-Cal managed care is a delivery system we should continue to invest in and rely upon. In conjunction with these new and increased responsibilities, DHCS plans to increase oversight of the plans and their delegated entities to ensure that current requirements being met but also that the additional benefits and requirements contained in CalAIM are truly being provided statewide.

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to Medi-Cal managed care upon implementation of this proposal in 2022:

- Trafficking and Crime Victims Assistance Program (except share of cost)
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage

- Beneficiaries living in rural zip codes

Below are the populations that currently receive benefits through the fee-for-service delivery system except in COHS and CCI counties that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2023:

- All dual and non-dual individuals eligible for long-term care services (includes long-term care share of cost populations)
- All partial and full dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment upon implementation of this proposal in 2022:

- Omnibus Budget Reconciliation Act (OBRA): This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of Cost: beneficiaries in county organized health systems (COHS) and Coordinated Care Initiative counties excluding long-term care share of cost.

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

DHCS recommends keeping enrollment requirements for foster care children and youth in place until the Foster Care Workgroup makes recommendations on the future delivery system for foster care children and youth.

3.2.3 Rationale

Moving to mandatory managed care enrollment will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan. Transitioning current populations to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more

coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Additionally, DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.2.4 Proposed Timeline

- **January 1, 2022:** Non-Dual and pregnancy related aid code group, and population-based transitions, except for LTC aid codes.
- **January 1, 2023:** Dual aid code group transition, including LTC aid codes for both non-dual and dual beneficiaries.

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

3.3.1 Background

Under CalAIM, DHCS is proposing to transition CMC and the CCI to a statewide MLTSS and dual eligible special needs plan (D-SNP) structure. This policy is intended to help meet the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

The Coordinated Care Initiative has been underway in seven California counties and is comprised of two parts: 1) Cal MediConnect, a demonstration project that combined acute, primary, institutional, and home and community-based services into a single benefit package for individuals who are fully or partially eligible for Medicare and Medicaid; 2) mandatory Medi-Cal managed care enrollment for dual eligibles for all Medi-Cal benefits, including managed long-term services and supports.

The Governor's 2017-2018 budget determined that the Coordinated Care Initiative was not cost-effective due to the financing of the In-Home Supportive Services benefit, which was carved out to fee-for-service effective January 1, 2018. DHCS will carve out Multipurpose Senior Services Program services to fee-for-service effective January 1, 2022 for all Medi-Cal members. CMS approved an extension for the remaining program elements – Cal MediConnect and mandatory managed long-term services and supports enrollment – until December 31, 2022.

While the Coordinated Care Initiative and Cal MediConnect offer the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties. Additionally, Cal MediConnect has been a complex program to administer.

DHCS is implementing a new approach to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

3.3.2 Proposal

Aligned Enrollment

DHCS will use selective contracting to move toward aligned enrollment in D-SNPs; beneficiaries will enroll in a Medi-Cal managed care plan and D-SNP operated by the same parent company to allow for greater integration and coordination of care.

- In CCI counties, aligned enrollment will begin in 2023. Cal MediConnect members will transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product.
- Aligned enrollment will phase-in in non-CCI counties as plans are ready. DHCS will require managed care plans to apply for aligned D-SNPs to be effective no later than contract year 2025.
- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their managed care plan) when aligned enrollment takes effect in their county will be in that D-SNP (allowing the beneficiary to stay in the non-aligned D-SNP). New enrollment in those non-aligned D-SNPs will be closed.

In conjunction with the aligned enrollment approach, starting in 2022 CMS will limit enrollment into Medicare Advantage (MA) plans that are D-SNP “look-alikes.” These are MA plans that offer the same cost sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population, such as risk assessments or care plans.

As outlined in the CMS Contract Year 2021 Medicare Advantage and Part D Final Rule:

- CMS will not enter into contracts with new MA plans that project 80 percent or more of the plan's enrollment will be entitled to Medicaid starting in 2022; and
- CMS will not renew contracts with MA plans (except SNPs) that have enrollment of 80 percent or more enrollees who are entitled to Medicaid (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals).

DHCS will also allow plans in CCI counties with managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans to transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP in 2022, prior to the end of CCI. This will provide better coordination of care, without reducing enrollment in Cal MediConnect plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D-SNP Integration Requirements

DHCS will require that all D-SNPs use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. DHCS will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate.

As DHCS implements aligned enrollment, DHCS will require D-SNPs to:

- Develop and use integrated member materials.
- Include consumers in their existing advisory boards.
- Work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and managed care plans.
- Include dementia specialists in their care coordination efforts.
- Coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.

Additionally, DHCS will work with CMS to coordinate audit timing, to avoid a D-SNP/managed care plan being audited by both agencies at the same time.

Long-Term Care Carve In

In conjunction with mandatory Medi-Cal managed care enrollment, DHCS will require statewide integration of LTC into managed care for Medi-Cal populations by 2023. This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in Medi-Cal managed care by 2023.

D-SNP Transitions and Enrollment Policies

DHCS will encourage aligned enrollment of dual eligibles into matching managed care plans and D-SNPs to promote more integrated care. During all transitions, DHCS will work with CMS to ensure beneficiaries receive continuity of care protections.

Mandatory Enrollment into Medi-Cal Managed Care Plans

DHCS is committed to providing beneficiary and provider education, as well as technical assistance around Medi-Cal managed care plan requirements, for mandatory enrollment of dual eligibles into Medi-Cal managed care. As part of this work, DHCS will:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into a managed care plan or PACE for their Medi-Cal benefits.

- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

3.3.3 Rationale

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. California has made significant progress in building integrated systems through the implementation of CCI and CMC in seven counties (Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara). As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into managed care plans for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their managed care plan.

In addition, to promote integrated, person-centered care, the D-SNP and MLTSS policies will rely on California's robust and diverse array of HCBS providers across the state who serve older Californians and people with disabilities. In support of this effort, DHCS plans to submit a request for supplemental funding through the federal Money Follows the Person grant to accelerate LTSS system transformation design and implementation, and to expand HCBS capacity. The one-time supplemental funding would be used to develop a multi-year roadmap for implementing strategies and solutions for strengthening HCBS and MLTSS programs and provider networks. DHCS' intent is that the roadmap will provide a unified vision to integrate CalAIM MLTSS, D-SNP policy and the related in lieu of services policy, other components of the Master Plan on Aging, and all of HCBS, to expand and better link those HCBS to Medi-Cal managed care and D-SNP plans.

3.3.4 Proposed Timeline

- **January 1, 2021:** All existing D-SNPs must meet new regulatory integration standards effective 2021.

- **January 1, 2022**: Voluntary in lieu of services in all Medi-Cal managed care plans and CMC plans. Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties. Plans in CCI counties with existing managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP.

- **December 31, 2022**: Discontinue CMC and CCI.

- **January 1, 2023**: Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible LTC residents and statewide integration of LTC into Medi-Cal managed care. Aligned enrollment begins in CCI counties and managed care plans in those counties must stand up D-SNPs. All CMC members cross-walked to matching D-SNP and managed care plans, subject to CMS and state requirements.

- **January 1, 2025**: Aligned enrollment begins in non-CCI counties; All managed care plans required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit).

- **January 1, 2027**: Implement MLTSS statewide in Medi-Cal managed care.

3.4 NCQA Accreditation of Medi-Cal Managed Care Plans

3.4.1 Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, population health management, network management, utilization management, credentialing and re-credentialing, and member experience. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. Currently, 26 states require NCQA accreditation for their contracted Medicaid managed care plans.

DHCS conducts annual medical audits of all Medi-Cal managed care plans, but does not currently "deem," or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal regulations permit the state to deem this information for credentialing purposes.

DHCS does not currently require Medi-Cal managed care plans to be accredited by NCQA. Out of 24 full scope Medi-Cal managed care plans in the state, 17 health plans currently have NCQA accreditation. Medi-Cal managed care plans that provide private coverage through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

3.4.2 Proposal

To streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their

health plan subcontractors to be NCQA accredited by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal managed care plans meet particular state and federal Medicaid requirements. However, numerous stakeholders have shared with DHCS their concerns around DHCS deeming any elements of its current oversight of the managed care plans. Before DHCS recommends deeming of elements of its annual medical audits of the plans, DHCS will solicit feedback on the proposed deemable elements. If deeming does occur, DHCS will post information on the deeming elements and the corrective action plan for NCQA oversight findings on its website. DHCS will not accept accreditation from entities other than NCQA (e.g. URAC). Additional information on proposed deeming is below.

DHCS will also require Medi-Cal managed care plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027; the exact effective date for the LTSS Distinction Survey will be determined at a later date. Requiring the LTSS Survey will align with the state's effort to carve-in long-term care services and expand in lieu of services to make MLTSS a statewide benefit.

While DHCS is interested in the potential future addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as it could potentially maximize the opportunity for streamlining state compliance and deeming, DHCS has determined that it is premature to require the MED module at this point, given how new it is for NCQA.

Finally, DHCS had considered requiring Medi-Cal managed care plans to ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function. DHCS will not require this in its contracts with the Medi-Cal managed care plans at this time; Medi-Cal managed care plans will need to determine if they will require any accreditation of their non-health plan subcontractors. If DHCS decides to deem particular elements of NCQA health plan accreditation standards, and any Medi-Cal managed care plans elect to require NCQA accreditation of their subcontractors, the Medi-Cal managed care plans will have the option to offer deeming on those same elements, if applicable, with their subcontractors.

3.4.3 Rationale

One of the three objectives of CalAIM is to reduce variation and complexity across Medi-Cal delivery systems, including standardization of the Medi-Cal managed care benefit. requiring NCQA accreditation of its managed care plans and following the NCQA framework, DHCS can potentially increase standardization throughout the state and reduce redundancies in various processes and assessments, in areas such as care coordination, which DHCS currently requires. Further, NCQA accreditation can assist in streamlining DHCS monitoring and oversight of managed care plans, particularly with regard to the annual medical audits, by increasing the number of elements in which DHCS may consider deeming Medi-Cal managed care plans. This would allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

The addition of the LTSS Distinction Survey aligns with DHCS' goal of making LTSS a statewide benefit. DHCS recognizes that the addition of this survey to routine NCQA accreditation may be difficult for Medi-Cal managed care plans that are not already NCQA accredited, so DHCS will determine a timeframe for requiring the LTSS Distinction Survey that falls after all managed care plans have achieved routine NCQA plan accreditation.

3.4.4 Proposed Timeline

DHCS will require all Medi-Cal managed care plans and their health plan subcontractors to be NCQA accredited by 2026.

- DHCS will review and consider elements of NCQA health plan accreditation standards for deeming in relation to the annual A&I compliance audits.
    - DHCS will ensure that a complete crosswalk of federal and state Medicaid requirements and NCQA health plan accreditation standards is available online for comment prior to finalizing any deeming decisions.
    - DHCS will ensure that any NCQA health plan accreditation elements selected for potential deeming are vetted with stakeholders prior to finalizing any deeming decisions.
- DHCS may consider implementing deeming of the select elements sooner than 2026 for Medi-Cal managed care plans that already have NCQA accreditation. DHCS will align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following six NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2026:
    - Quality Improvement;
    - Population Health Management;
    - Network Management;
    - Utilization Management;
    - Credentialing; and
    - Member Experience.

3.5 Regional Managed Care Capitation Rates

3.5.1 Background

DHCS currently develops, certifies, and implements managed care capitation rates on an annual basis for contracted Medi-Cal managed care plans. DHCS develops distinct rates for each contracted managed care plan by county/region and population group. Due to the complexities of the Medi-Cal managed care program, which includes varied and intricate financing mechanisms, DHCS calculates multiple rating components for each capitation rate for a total of more than 4,000 rating components on an annual basis as of

state fiscal year 2018-19. The excessively large number of rating components DHCS must develop on an annual basis is administratively burdensome and contributes to lengthy annual federal review and approval timeframes. It also limits DHCS' ability to advance value-based and outcomes-focused rate setting methodologies. With the changes contemplated in CalAIM, DHCS views the need for simplified methodologies with a reduced number of components as necessary to achieving our broader goals of improving care delivery, access, quality and outcomes for our Medi-Cal beneficiaries.

3.5.2 Proposal

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

To ensure a successful transition, DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2022 and 2023 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2024, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

3.5.3 Rationale

The proposed transition to regional rates statewide offers four main benefits:

- Regional rates would reduce the number of distinct rating components that DHCS must develop on an annual basis, and thereby permit DHCS to utilize a more flexible rate structure model. This flexibility is essential to DHCS' ability to pursue

advancements and innovations in the Medi-Cal managed care program, including CalAIM, and to explore new, innovative ideas.

- Regional rates would simplify the presentation of rates to CMS, which may expedite federal review and approval of the Medi-Cal managed care capitation rates. DHCS could implement rate-setting approaches that promote efficiency, including cost-averaging processes, across Medi-Cal managed care plans.
- These approaches would continue to incentivize Medi-Cal managed care plans to operate efficiently as rates will be based upon costs across the multi-county region. In effect, each Medi-Cal managed care plan will be incentivized to compete to be more efficient than other plans in their region.
- Regional rates would provide a larger, multi-county base for averaging, and thereby alleviate some of the criticisms regarding the process currently used by DHCS.

3.5.4 Proposed Timeline

Rate setting is a dynamic process. Therefore, DHCS will proceed methodically, engage and collaborate with Medi-Cal managed care plans, and make future refinements as determined actuarially appropriate.

- **Calendar Year 2020 and 2021:** Develop regional rate-setting methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Implement Phase I for targeted counties and Medi-Cal managed care plans.
- **Calendar Year 2023:** Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide.
- **No sooner than January 1, 2024:** Fully implement regional rates statewide.
- **Post-implementation:** Continue to evaluate and refine the rate-setting process and regions.

Behavioral Health

3.6 Behavioral Health Payment Reform

3.6.1 Background

Through realignment efforts in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the specialty mental health and substance use disorder (SUD) services became the responsibility of the counties. Currently, counties are reimbursed for the federal and state portion of costs for services and administration of these programs via Medicaid Certified Public Expenditure (CPE) methodologies. Under

CPE methodologies, reimbursements to counties are limited to costs incurred by the counties and are subject to a lengthy and labor-intensive cost reconciliation process.

For specialty mental health services, counties pay with non-federal funds at the time of service and when incurring costs to administer the programs. The counties then submit CPEs to DHCS so that the state can draw down eligible federal Medicaid matching funds. In accordance with the CMS-approved CPE protocol, mental health plans receive interim reimbursement of federal financial participation on a fee-for-service basis, pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes. The state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state fiscal year. The final cost reconciliation of mental health plan interim Medicaid payments occurs within 36 months after the certified, reconciled, state-developed cost reports are submitted.

The Drug Medi-Cal portions of the State Plan establishes the interim payment methodology for both Narcotic Treatment Program and non-Narcotic Treatment Program services. Generally, this methodology requires an interim reimbursement at the statewide maximum allowable or uniform statewide daily dosing rate. DHCS also provides an interim reimbursement to counties for costs incurred to administer DMC-ODS or DMC programs. After the fiscal year ends, DHCS performs a settlement with counties for the cost of administering the SUD services (either through DMC State Plan or through DMC-ODS). These cost reconciliations occur years after the close of the state fiscal year to allow time for claims run out as well as for DHCS to complete its cost reconciliation audits.

To incentivize additional investment in the delivery systems and reduce overall burden on counties and the state, DHCS is proposing to reform behavioral health payment methodologies for counties. Under the current CPE methodology, counties are not able to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

3.6.2 Proposal

The state is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from CPE-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible; and
- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided by counties via intergovernmental transfer instead of CPEs, eliminating the need for reconciliation to actual costs.

Transition from HCPCS Level II Coding to CPT Coding

DHCS is proposing to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code.

For specialty mental health services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: therapy, assessments, treatment planning, rehabilitation, prescribing medication, administering medication, patient education, and crisis intervention. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Services that currently receive a bundled rate, such as psychiatric inpatient hospital services, adult residential treatment, crisis residential treatment, psychiatric health facility services, crisis stabilization, day treatment, and day rehabilitation, would continue to be reimbursed using a bundled rate.

For SUD services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: assessment, case management, crisis intervention, discharge planning, group counseling, individual counseling, medical psychotherapy, prescribing medication, administering medication, recovery services, and treatment planning. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Narcotic Treatment Programs would continue to be reimbursed a daily rate for each encounter.

Rate Setting Methodology

For the establishment of reimbursement rates, DHCS is proposing to set rates by peer grouping. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component. Additionally,

DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services, administration, and required utilization management/quality assurance activities.

To start, DHCS is proposing to process intergovernmental transfers and make payments to counties on a monthly basis. Eventually, DHCS plans to transition to quarterly intergovernmental transfers and payments to reduce the administrative burden tied to processing intergovernmental transfers and payments for 58 counties on a monthly basis. The state will discuss with the counties the appropriate time to transition from monthly to quarterly payments.

3.6.3 Rationale

Under CPE-based methodologies, all reimbursement is limited to the actual cost of providing services, which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The shift from CPE to intergovernmental transfer-based methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;
- Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce state and county administrative burden and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Finally, the shift from HCPCS Level II coding to HCPCS Level I coding will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers. The shift in coding will also allow counties and DHCS to better report performance outcomes and measures. In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

3.7.4 Proposed Timeline

Given the need to ensure county readiness for this change in approach, DHCS is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate county readiness and develop a strategy to support them in making this transition. However, the earliest date the shift would occur would be July 1, 2022.

The transition from cost-based reimbursement to an established rate schedule would take place concurrently with the adoption of the HCPCS Level I coding. DHCS would, initially, establish separate rate schedules for specialty mental health and substance use disorder services, with the goal of aligning rate schedules when these services are administratively integrated into a single behavioral health managed care program. DHCS would begin the intergovernmental transfer-based reimbursement at the start of a state-county fiscal year to ease the transition.

3.7 Medical Necessity Criteria

3.7.1 Background

Current medical necessity criteria for specialty mental health services are outdated and confusing and can lead to challenges for beneficiaries in accessing appropriate care. Current diagnosis requirements can prevent beneficiaries from receiving urgently needed care, especially for children, who are entitled to care before developing a mental health condition, or for people with a co-occurring substance use disorder whose diagnosis may not be immediately clear. DHCS requirements for provider documentation are confusing and may lead to provider burden and risk of payment disallowance during audits.

Currently, DHCS does not standardize screening practices to determine where a beneficiary should initially seek mental health care. As a result, counties and plans have a variety of approaches to determine where beneficiaries should initially access care, whether with county Mental Health Plans (for specialty mental health services) or with Medi-Cal Managed Care or Fee for Service delivery systems (for beneficiaries not meeting criteria for specialty mental health services). DHCS does not currently standardize how beneficiaries transition across these delivery systems when their status changes, leading to inconsistent practices. In addition, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protection for beneficiaries under age 21 is inconsistently interpreted and leads to confusion and variation in practice.

3.7.2 Proposal

With the CalAIM initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure beneficiary access to the right care in the right place at the right time.

In CalAIM, DHCS proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met.

DHCS proposes to clarify EPSDT protections for beneficiaries under age 21, and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness.

DHCS proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed are or fee for service system. In addition, DHCS proposes to develop a standardized transition tool, for when a beneficiary's condition changes, and they would be better served in the other delivery system.

DHCS proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

DHCS also proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout.

With respect to inpatient specialty mental health services, DHCS proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations. To facilitate improved communication between mental health plans and hospitals, and to decrease variation in clinical documentation requests across counties, DHCS will develop, in consultation with hospital and county stakeholders, documentation standards and concurrent review protocols to allow efficient and streamlined communication of clinical information during concurrent review.

Division of Services Between Mental Health Plans and Medi-Cal Managed Care Plans

To ensure beneficiaries with behavioral health needs are guided to the most appropriate delivery system to address their needs, DHCS is proposing to update its medical necessity criteria and processes, which would be organized as described below:

California provides Medi-Cal mental health services through Managed Care Plans, Fee for Service (FFS), and county mental health plans. The delivery system responsible to provide the mental health service depends on the degree of a beneficiary's impairment from the mental health condition and other criteria described below. Beneficiaries may receive mental health services prior to diagnosis in any of these delivery systems under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. Beneficiaries may initiate medically necessary mental health services in one delivery system and receive ongoing services in another system. Beneficiaries whose degree of impairment changes may transition between the delivery systems, or under some circumstances may receive medically necessary mental health services in more than one delivery system. Care shall be coordinated between the delivery systems and services shall not be duplicated.

Medi-Cal Managed Care Plan responsibilities:

The following nonspecialty mental health services are covered by managed care plans:

a) Individual and group mental health evaluation and treatment (including psychotherapy and family therapy);
b) Psychological testing, when clinically indicated to evaluate a mental health condition;
c) Outpatient services for the purposes of monitoring drug therapy;
d) Psychiatric consultation; and,
e) Outpatient laboratory, drugs, supplies and supplements (note: the pharmacy benefit will be carved out of managed care plans contracts and transitioned to fee for service delivery under Medi-Cal Rx as of 4/1/2021).

Medi-Cal managed care plans are responsible to provide the above nonspecialty mental health services to adult beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders. Managed care plans are also required to provide non-specialty mental health services to children under the age of 21. Managed care plans are also responsible to provide mental health services to beneficiaries with potential mental health disorders

These services are also available in the FFS mental health delivery system for beneficiaries not enrolled in Medi-Cal managed care.

County Mental Health Plan responsibilities:

For beneficiaries 21 years and over, Mental health plans are responsible to provide specialty mental health services for beneficiaries who meet (A) and (B) below:

(A): The beneficiary must have one of the following:

(i) Significant impairment ("impairment" is defined as distress, disability or dysfunction in social, occupational, or other important activities), OR
(ii) A reasonable probability of significant deterioration in an important area of life functioning.

(B): The beneficiary's condition in (A) is due to:

(i) A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), OR

(ii) A suspected mental disorder that has not yet been diagnosed.

For beneficiaries under age 21[1],
Mental health plans are responsible to provide specialty mental health services to beneficiaries who meet either Criteria 1 **or** Criteria 2:

Criteria 1: The beneficiary is at high risk for a future mental health disorder due to experience of trauma, evidenced by: scoring in the high-risk range on a DHCS-approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness.

Criteria 2: The beneficiary must meet both (A) and (B), below:

(A): The beneficiary must have at least one of the following:

I. Significant impairment, or
II. A reasonable probability of significant deterioration in an important area of life functioning, or
III. iii. A reasonable probability a child will not progress developmentally as appropriate, or
IV. Less than significant impairment, but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.

(B): The beneficiary's condition in (A) is due to:
I. A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), or
II. A suspected mental disorder that has not yet been diagnosed.

Mental health plans provide the following specialty mental health services

1. Crisis Residential Treatment Services
2. Adult Residential Treatment Services
3. Crisis Interventions
4. Crisis Stabilization
5. Day Rehabilitation
6. Day Treatment Intensive
7. Medication Support Services
8. Psychiatric Health Facility Services

[1] The Early and Periodic Screening, Prevention and Treatment protection entitles beneficiaries under age 21 to services necessary to correct or ameliorate a mental illness and condition recommended by a qualified provider operating within his or her scope of practice, whether or not the service is in the state plan.

9. Psychiatric Inpatient Hospital Services
10. Targeted Case Management/Intensive Care Coordination
11. Mental Health Services and Intensive Home-Based Services (including the following service interventions: Assessment, Plan Development, Therapy, Rehabilitation, and Collateral)
12. Therapeutic Behavioral Services
13. Therapeutic Foster Care Services

Substance Use Disorder Services

As with the current SMHS medical necessity criteria, the current Section 1115 waiver for SUD services requires beneficiaries to be diagnosed with a SUD to meet criteria for reimbursement, preventing the provision of treatment services prior to a definitive diagnosis.

As for mental health, DHCS proposes that substance use disorder treatment services may be provided and reimbursed prior to the determination of a diagnosis, including providing services to beneficiaries with co-occurring mental health disorders.

In addition, DHCS heard many comments from stakeholders about how to improve the Drug Medi-Cal Organized Delivery System, which are reflected in the "DMC-ODS Program Renewal and Policy Improvements" section of this proposal.

Documentation Requirements for Specialty Mental Health and Substance Use Disorder Services

Documentation requirements for SUD and SMHS are currently stringent. Stakeholders report that concern about disallowances result in providers spending an excessive amount of time "treating the chart instead of treating the patient." With the goal of aligning standards across physical and behavioral health programs, DHCS is proposing to update documentation requirements for specialty mental health and substance use disorder treatment to simplify and streamline requirements. For example, DHCS proposes to eliminate the requirement for a point-in-time treatment plan signed by the client, with progress notes tying to the treatment plan. Evidence does not show that shared decision-making is achieved through signature requirements, and the requirement that every note and every intervention must tie to a treatment plan is inefficient and inconsistent with documentation requirements in the medical (physical health) system. DHCS proposes to align behavioral health and medical documentation requirements in Medi-Cal by requiring problem lists and progress notes to reflect the care given and to align with the appropriate billing codes. DHCS also proposes to revise the clinical auditing protocol, to use disallowances when there is evidence of fraud, waste, and abuse, and to use quality improvement methodologies (such as oversight from the External Quality Review Organization) for minor clinical documentation concerns. These documentation changes will align with behavioral health payment reform, as the use of Level 1 HCPCS codes comes with national documentation standards and expectations.

Technical Corrections

DHCS proposes to make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), rather than the more current DSM-V, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

3.7.3 Rationale

Updates to medical necessity criteria for specialty mental health and SUD services, and related policy proposals, are required to achieve more up-to-date clinical practices and better clarity for oversight.

3.7.4 Proposed Timeline

DHCS recommends making changes to the specialty mental health and substance use disorder medical necessity criteria and related processes, as applicable, effective January 1, 2022 with the approval of the Section 1115 and 1915(b) waivers.

3.8 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

3.8.1 Background

California's mental health plans operate under the authority of a Section 1915(b) waiver, while DMC-ODS plans operate under the authority of a Section 1115 demonstration, and Drug Medi-Cal fee-for-service programs are authorized through California's Medicaid State Plan.

For mental health plans and DMC-ODS plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and DMC-ODS treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the DMC-ODS managed care program is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Fifty-six mental health plans administer the SMHS program, including two joint arrangements in Sutter/Yuba and Placer/Sierra. For SUD services, 37 counties administer the DMC-ODS program, covering more than 90 percent of the Medi-Cal population. Seven of these counties contract with a local Medi-Cal managed care plan to provide an alternative regional model for DMC-ODS. The remaining 21 counties provide SUD treatment services through Drug Medi-Cal.

Medi-Cal specialty mental health and SUD treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and SUD treatment needs must navigate multiple systems to access care.

Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both SUDs and mental health conditions.

At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For DMC-ODS counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

3.8.2 Proposal

DHCS is proposing administrative integration of specialty mental health and SUD services into one behavioral health managed care program. This proposal is distinct from the Full Integration Plan which will integrate physical, behavioral and oral health care into comprehensive managed care plans. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state.

For counties participating in DMC-ODS managed care, DHCS is interested in working toward integrating the two behavioral health programs/prepaid inpatient health plans into a single behavioral health plan structure. The result would be a single prepaid inpatient health structure in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease their administrative burden.

Additionally, Drug Medi-Cal fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Clinical Integration

1. Access Line

Counties are required to have a 24-hour access line for mental health plans and for DMC-ODS. Some Drug Medi-Cal counties may also have 24-hour access lines, although it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental

health and SUD treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or SUD services.

2. Intake/Screening/ Referrals

Processes for intake, screening, and referral vary by county. Optimally, counties would have standardized and streamlined intake processes that are timely, emphasize a positive beneficiary experience, and use a "no wrong door" approach to help beneficiaries access mental health and substance use disorder services. While assessments are performed by clinicians and tailored to the needs of the client, and may vary based on setting, DHCS proposes to move forward with a standardized statewide screening tool for beneficiaries 21 and over, and one for beneficiaries under 21, to ensure beneficiaries receive prompt care in the right delivery system.

3. Assessment

Assessment processes and tools for specialty mental health and SUD services also vary by county. For example, the American Society of Addiction Medicine placement tool is used to make level of care determinations DMC-ODS. However, an assessment tool is not required in Drug Medi-Cal counties. For SMHS, the Child and Adolescent Needs and Strengths tool is required for children and youth; however, there is not a required tool for adults. More research will be needed to determine which aspects, authorities, or requirements need to be addressed to integrate clinical assessments for mental health and SUDs.

4. Treatment Planning

Currently, treatment planning for specialty mental health and SUD treatment services is conducted separately and is not integrated. Beneficiaries receiving both types of services can have multiple treatment plans that include different documentation requirements. To improve efficiency, counties would integrate treatment planning for both specialty mental health and substance use disorder services with simplified and aligned documentation requirements. The goal would be to develop a new, simplified, more client-centered and strength-based approach to behavioral health treatment planning and to align treatment planning and documentation standards with physical health care. Additionally, DHCS will provide counties with relevant Medi-Cal services data, which may include managed care encounter and pharmacy claims data, to allow for better coordination of care and treatment planning.

5. Beneficiary Informing Materials

Currently, beneficiaries who receive services through mental health plans and DMC-ODS receive two beneficiary handbooks. The handbooks are not the same, but both

address elements that are required by federal managed care regulations, such as language regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.

Consideration would need to be given to implementing this element in Drug Medi-Cal counties, since they are not currently required to have a beneficiary handbook.

Administrative Integration

1. Contracts

Currently, there are three separate contract types between DHCS and counties: mental health plans, DMC-ODS and Drug Medi-Cal counties. Under an integrated system, the goal would be to have only one contract in every county that would cover both all Medi-Cal specialty mental health and SUD treatment services.

2. Data Sharing / Privacy Concerns

Counties are responsible for managing data-sharing at two levels: within and across county plans, and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for SMHS and SUD services. Addressing these concerns will be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes. A thorough assessment of the various barriers and solutions to stringent patient privacy protections will be required. There will need to be a thorough assessment by the state and counties to identify the various barriers and solutions to stringent patient privacy protections built into federal regulations.

3. Electronic Health Record Integration and Re-Design

Many counties currently operate separate electronic health records (EHRs) or maintain differently configured and separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs. Timelines for integrating different components of administrative integration will depend on counties' ability to arrive at a record design that is compliant and then collaborate with their vendors to make multiple, timely modifications to their electronic health records.

4. Cultural Competence Plans

Mental health plans are required to have a plan for culturally responsive care for specialty mental health services. DMC-ODS plans are also required to have a culturally responsive care plan. Under an integrated system, counties would have only one integrated plan for culturally responsive care instead of two, separate plans.

Considerations would need to be given to how this element would be implemented in Drug Medi-Cal counties since they are currently not subject to these same requirements.

Integration of DHCS Oversight Functions

1. Quality Improvement

Some counties have integrated quality improvement and performance measurement programs for specialty mental health and substance use disorder services. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.

2. External Quality Review Organizations

Pursuant to federal Medicaid managed care requirements, an external quality review is required for both mental health plans and DMC-ODS. Currently, Behavioral Health Concepts is the contractor that acts as the External Quality Review Organization for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single External Quality Review Organization (EQRO) report for each county. Since an external quality review is not required for Drug Medi-Cal counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.

3. Compliance Reviews

Current compliance reviews conducted by DHCS for mental health plans, DMC-ODS, and Drug Medi-Cal counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. A particular focus of this effort will be on streamlining documentation requirements for behavioral health providers to allow integrated behavioral health care.

4. Network Adequacy

Network adequacy certification processes are separate for specialty mental health plans and DMC-ODS. Under an integrated model, DHCS would certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required.

5. Licensing & Certification

Existing requirements and processes for licensing and certification are different and separate for specialty mental health and substance use disorder providers. The goal is to streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system, where appropriate. Successful implementation of integrated care models would also necessitate a discussion on non-administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

3.8.3 Rationale

About half of individuals with a SMI have a co-occurring substance use and those individuals benefit from integrated treatment. Since the state provides Medi-Cal-covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, it is difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties with both DMC-ODS and mental health plans are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. The purpose of this proposal is to make changes to streamline the administrative functions for SUD and SMHS.

3.8.4 Proposed Timeline

The goal would be to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver in 2027. Both state-level and county-level activities will be required to achieve this goal. Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.

3.9 Behavioral Health Regional Contracting

3.9.1 Background

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of specialty mental health services. Furthermore, participating DMC-ODS counties are permitted to develop regional delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

3.9.2 Proposal

DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program or the local Medi-Cal managed care plan, to create administrative efficiencies across multiple counties.

Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under Drug Medi-Cal might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

3.9.3 Rationale

Acting jointly through regional contracts would allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region and allow for increased county administrative efficiencies. Although regional contracting is currently allowed under state law, only a few counties have taken advantage of this opportunity. Regional contracting would give counties opportunities to share workforce and jointly invest in administrative infrastructure such as electron health records, billing and claiming systems, and oversight/quality assurance and improvement.

Regional contracts offer numerous potential advantages. For example, network adequacy certification requires significant administrative infrastructure to develop and maintain policies and procedures for tracking network resources, and counties must identify and contract with additional qualified providers when network gaps are identified. Both functions (tracking and finding new providers) can prove challenging in some counties that may have fewer local providers. Through regional contracts, counties could reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes.

For Drug Medi-Cal counties, regionalization could potentially enable smaller counties to participate in DMC-ODS, providing a broader set of services to their residents when it would not be otherwise feasible. By participating in DMC-ODS, these counties could then create a single, integrated behavioral health plan, as described in the CalAIM Administrative Integration of Specialty Mental Health and Substance Use Disorder Services proposal.

In addition, Medi-Cal managed care plans, mental health plans, and DMC-ODS plans must meet the full array of state and federal requirements applicable to prepaid inpatient health plans under the federal Medicaid managed care regulations. Among these are network adequacy, quality assessment and performance improvement, beneficiary rights and protections, and program integrity. For individual counties, entering into regional contracting agreements would reduce the administrative burden of meeting Medicaid managed care requirements. Counties could better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

3.9.4 Proposed Timeline

DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

3.10 Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

3.10.1 Background

One of the key goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) was to treat more people more effectively by reorganizing the delivery system for substance use disorder (SUD) treatment through Medi-Cal. California's Drug Medi-Cal Organized Delivery System (DMC-ODS) was the nation's first SUD treatment demonstration project under Section 1115, approved by CMS in 2015. Since then, more than 20 other states have received approval for similar substance use disorder treatment demonstrations. The program has established a continuum of care modeled after the American Society for Addiction Medicine (ASAM) criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction.

The benefits under the DMC-ODS, which counties administer as pre-paid inpatient health plans (PIHPs), include all of the standard SUD treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, narcotic treatment programs and naltrexone), plus case management, multiple ASAM levels of residential substance use disorder treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional medication assisted treatment, and partial hospitalization.

Also included in the current program is the expenditure authority to allow federal Medicaid reimbursement for short-term residential SUD treatment stays in an Institution for Mental Disease (IMD). The IMD exclusion has historically prohibited federal reimbursement for residential and inpatient mental health and SUD treatment for Medicaid enrollees age 21-64, in facilities with more than 16 beds. This exclusion deterred most providers in the State who found it financially unviable to operate facilities with so few beds. Allowing for reimbursement of residential SUD treatment services through the Medi-Cal program, with

no limitation on the number of beds, means that counties can receive federal matching funds for services that were previously unavailable.

Currently, DMC-ODS is not a statewide benefit since the program operates only in counties that "opt in" to participate and are approved to do so by both DHCS and CMS. There are currently 37 counties participating in the DMC-ODS demonstration, providing access to SUD treatment services for 96 percent of the Medi-Cal population. Seven of these counties are working with a local managed care organization to implement a regional model. Medi-Cal beneficiaries in the 21 counties not participating in the program provide their SUD treatment services through fee-for-service as authorized through the Drug Medi-Cal State Plan. The fee-for-service benefit is more limited than the DMC-ODS benefit in terms of covered services and that it is not a managed care program.

3.10.2 Proposal

DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation. Accordingly, DHCS proposes to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.

DHCS aims to design a cohesive plan to address beneficiaries' SUD treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and to promote long-term recovery. This requires developing new approaches to care delivery and system administration that will improve the beneficiary experience, increase efficiency, ensure cost-effectiveness, and achieve positive health outcomes.

The 37 counties that have implemented the DMC-ODS have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with SUD treatment needs. Implementation across 37 California counties has also yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also acknowledges that for many counties, the DMC-ODS model of care is still very new since implementation was phased in over several years.

Accordingly, DHCS solicited input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level.

DHCS also intends to provide counties with another opportunity to opt-in to participate in the DMC-ODS in hopes of promoting DMC-ODS participation across the state. While participation in DMC-ODS will not be mandatory for counties, DHCS would like to work with counties not currently participating in the DMC-ODS to explore ways to encourage the remaining counties to opt-in.

Residential Treatment Length-of-Stay Requirements

Currently, within a 365-day period, adult residential SUD treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays.

Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from SUDs, DHCS proposed in the 12-month extension request to remove this limitation and base treatment on medical necessity.[2] DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements.

Note: DHCS must obtain approval from CMS regarding all components of the Section 1115 extension and renewal. CMS is currently only approving SUD 1115 demonstrations with a residential benefit average length-of-stay of 30 days. While some states may show average lengths of stay that are close to the 30-day target, these are likely to include numerous treatment episodes that may have terminated prematurely, before the client achieved positive clinical outcomes. Including these shorter stays in the calculation may lower the average and give the impression that shorter lengths of stay are universally feasible and appropriate.

As such, DHCS will examine the possibility of tracking and documenting the average length-of-stay for only those DMC-ODS enrollees that achieve positive treatment outcomes. Furthermore, with the substantial rise in methamphetamine usage and overdose deaths in California, DHCS will work closely with CMS to negotiate a residential treatment benefit that accounts for the increased clinical needs of individuals utilizing stimulants.

[2] Proposed changes to the DMC-ODS program included in the Medi-Cal 2020 12-month extension request: 1) Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period, 2) Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis, 3) Clarify that recovery services benefit, 4) Expand access to MAT, and 5) Increase access to SUD treatment for American Indians and Alaska Natives.

Residential Treatment Definition

The current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS would also propose to remove the distinction between adults and adolescents for these requirements, with the exception of Early and Periodic Screening, Diagnostic, and Treatment services.

Recovery Services

As part of Dimension 6 (Recovery Environment) of the ASAM criteria, during the transfer/transition planning process, beneficiaries shall be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposed in the 12-month extension to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term “after completing their course of treatment,” to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.

If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026.

Additional Medication Assisted Treatment

Counties are required to cover opioid treatment program services, also called Narcotic Treatment Programs. Currently counties may elect to cover additional medication assisted treatment, which includes the ordering, prescribing, administering, and monitoring of all medications for SUD treatment.

DHCS proposed in the 12-month extension request to keep the additional medication assisted treatment (MAT) services as an optional benefit but clarified the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to medication assisted treatment. The goal is to have a county-wide multi-delivery system of coverage.

Clinician Consultation Services

Currently, physician consultation services cover time spent by the DMC-ODS physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. The name of the benefit will change to Clinician Consultation Services and be expanded to include consultation services for, and by, licensed clinicians including Nurse Practitioners and Physician Assistants. Coverage of consultation services is designed to help clinicians seek expert advice on designing treatment plans for beneficiaries. Clinician consultation services can only be billed and reimbursed by providers in DMC-ODS provider sites.

DHCS proposes to clarify the terms of clinician consultation, particularly with regard to how and who can claim this activity. DHCS proposes to remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers. Counties may contract with SUD clinicians not certified by Drug Medi-Cal. DHCS' telehealth policy will be used to guide this effort.

Evidence-Based Practice Requirements

Currently, providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. The two evidence-based practices are a per-provider per-service modality.

DHCS proposes to retain the five (5) current evidence-based practices and add Contingency Management to the renewal proposal. Providers are not limited to providing only the six evidence-based practices.

DHCS Provider Appeals Process

Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.

DHCS proposes removing this process from as it is convoluted, has rarely been used, and it is already addressed by the network adequacy requirements. All providers have a right to appeal under the federal 438 requirements.

Tribal Services

DHCS proposed in the 12-month extension to take several actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement, and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.

- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

These changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based substance use disorder treatment.

Treatment after Incarceration

The current language requiring the ASAM criteria, may be underestimating the level of care necessary to serve individuals being released from incarceration, since their substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use.

Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS plans to clarify access language for individuals leaving incarceration who have a known substance use disorder.

Billing for Services Prior to Diagnosis

Currently, counties may not begin billing for SUD services until a beneficiary has been diagnosed (i.e., counties may not bill for time spent conducting substance use disorder assessments). Since it takes time for clinicians to evaluate a beneficiary for a substance use disorder, and sometimes presenting symptoms are due to a combination of mental illness, substance use disorder, or both, DHCS proposed in the Medi-Cal 2020 extension to clarify the waiver Special Terms and Conditions to allow reimbursement for SUD assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with requirements around assessments for specialty mental health services.

Medical Necessity for Narcotic Treatment Programs (NTPs)

DHCS proposes to update and align the STCs with best practices to allow a physician's history and physical to determine medical necessity for NTP services as required by

federal licensing laws. In addition, DHCS would clarify requirements for the initial assessment and medical necessity determinations in other settings.

Early Intervention (Level 0.5)

DHCS proposes to add ASAM 0.5 level of care for beneficiaries under 21, to allow early intervention as an organized service that may be delivered in a wide variety of settings. This service is designed to explore and address problems or risk factors related to substance use, and to help the individual recognize the harmful consequences of high-risk substance use. This includes engagement activities (including screening, assessment, brief interventions such as motivational interviewing and counseling) for beneficiaries at high-risk for developing substance-related or addictive behavior problems, or those for whom there is not yet sufficient information to document a substance use disorder.

3.10.3 Proposed Timeline

The following changes would go into effect on January 1, 2021, subject to federal approval of the Medi-Cal 2020 12-month extension request:

- Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis
- Clarify that recovery services benefit
- Expand access to MAT
- Increase access to SUD treatment for American Indians and Alaska Natives.

The remaining changes outlined above would go into effect January 1, 2022, subject to federal approval.

Dental

3.11 New Dental Benefits and Pay for Performance

3.11.1 Background

DHCS is committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. To demonstrate that commitment, three initiatives and policy changes have been implemented in recent years:

- The Dental Transformation Initiative under the current Medi-Cal 2020 Section 1115 demonstration;
- Proposition 56 supplemental provider payments; and

- Restoration of the optional adult dental benefit under Medi-Cal.

These efforts have been successful in increasing preventive dental service utilization for children, as well as increasing adult utilization of dental care. While two of the initiatives share a common theme – financial incentives for positive outcomes – they are time-limited. DHCS has included a chart (see **Appendix H: Dental in Proposition 56 vs. CalAIM**) that reflects the dental codes with financial incentives available under CalAIM and Proposition 56.

3.11.2 Proposal

The Department set a goal to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children. In order to progress toward achieving that goal and based on lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide provide better care and align with national dental care standards. The proposed new benefits include:

- Caries Risk Assessment Bundle for young children; and
- Silver Diamine Fluoride for young children; and specified high-risk and institutional populations; and
- Expanded pay-for-performance initiatives that a) reward increasing the use of preventive services and b) reward establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult enrollees.

These expanded initiatives would be available statewide for children and adult enrollees.

New Dental Benefits

DHCS proposes adding coverage of a Caries Risk Assessment Bundle for children ages 0 to 6 years. The Caries Risk Assessment bundle would include nutritional counseling (D1310) to educate and influence behavior change. Based on risk level associated with each individual Medi-Cal beneficiary ages 0 to 6, the benefit would allow the following frequency of services:

- Low – comprehensive preventive services 2x/year (D0601)
- Moderate – comprehensive preventive services 3x/year (D0602)
- High – comprehensive preventive services 4x/year (D0603)

Additionally, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/ Intermediate Care Facility (SNF/ICF) or part of the Department of Developmental Services (DDS) population. The Silver Diamine Fluoride benefit would provide two visits per member per year, for up to ten teeth per visit, at a per tooth rate and a maximum of four treatments per tooth.

Pay for Performance

To increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment for each paid preventive service rendered by a service office location.

Additionally, the state proposes to provide an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row.

3.11.3 Rationale

These policy proposals align with the legislature's charge to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children, CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP children ages one to 20 who receive a preventive dental service), and our lessons learned from the Dental Transformation Initiative (DTI).

For example, in the DTI - Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased eight percent and the number of services per member has also increased by seven percent.

Furthermore, data comparing a control group of children in Dental Transformation Initiative counties who did not receive Caries Risk Assessment with children who did receive Caries Risk Assessment over two calendar years yielded staggering results. The Medi-Cal children who had a Caries Risk Assessment received over 300 percent more preventive services compared to 189 percent for non-Caries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Caries Risk Assessment had a 263 percent increase in restorative services while the control group with no Caries Risk Assessment had a 475 percent increase in restorative services.

3.11.4 Proposed Timeline

DHCS is currently evaluating a timeline for implementation as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration.

County Partners

3.12 Enhancing County Eligibility Oversight and Monitoring

3.12.1 Background

The implementation of the Affordable Care Act (ACA) marked a monumental overhaul of the Medi-Cal program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations. County social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted statewide. To afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post Affordable Care Act, counties were held harmless by DHCS for performance standards.

Federal, state, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act in 2014 have identified several issues that must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the state to repay the federal matching funds that were claimed because of erroneous Medi-Cal eligibility determinations.

3.12.2 Proposal

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards**: In response to audit findings, DHCS will reinstate the county performance standards required under state law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.

- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards**: In collaboration with CWDA, SAWS and the counties, DHCS will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. This process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.

- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.

- **Develop a Tiered Corrective Action Approach**: DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a Corrective Action Plan for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.

- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach**: For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring corrective action plans to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.

- **Incorporate Findings/Actions in Public Facing Report Cards**: DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services (CHHS) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

3.12.3 Rationale

This proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal enrollment processes are applied in a standardized and consistent manner statewide. This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS is compliant with federal and state requirements.

3.12.4 Proposed Timeline

Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

- **June 1 – August 31, 2021**: DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.

- **September 1 – December 30, 2021:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.

- **January 1 – March 31, 2022:** DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.

- **April 1 – June 30, 2022:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.

- **July 1 – September 30, 2022:** DHCS will begin publishing the county performance monitoring dashboard on the CHHS Open Data Portal.
- **July 1 – December 31, 2023:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

3.13 Enhancing County Oversight and Monitoring: CCS and CHDP

3.13.1 Background

The California Children's Services program serves as a proxy of Medi-Cal for case management services and provides diagnostic and treatment services, physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children's Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. It is the State's responsibility to ensure that the same high-quality standard of care is compliant with federal and State guidelines for all beneficiaries. To remain proactive with emerging trends, technology, medical advances, and interventions, it is essential the State continue to evolve its efforts accordingly.

3.14.2 Proposal

DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements. Ongoing quality assurance and data reviews are fundamental to ensuring compliance and continued improvements in program operations and beneficiary care.

Initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county/city operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across the State within the programs. The information gathered will be the cornerstone for future efforts, and the basis for the development of the strategic compliance program.

County/City variances in program operations and compliance with federal and State laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS, along with input from our county partners and other stakeholders, will establish goals, metrics, performance measures, and milestones to ensure counties/cities are providing the necessary provider oversight and medical/ dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop, and create county/city program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, the State plans to shift counties/cities from annual hardcopy submission of Plan and Fiscal Guidelines budgets to a more efficient and streamlined automated electronic submission process. Training and overview of the electronic submission process conducted for the counties ensures understanding prior to implementation of the automated system. More rigorous annual review of all county budgets will further efficiencies, contain costs, and improve outcomes.

To better manage this population's health care and ensure targeted interventions are implemented, each county/city and state will enter into a Memorandum of Understanding (MOU) with DHCS. The MOU, in conjunction with other supportive policies (information notices, numbered letters, etc.), will detail how the state will monitor county/city activities, policies and procedures, conduct audits, and implement corrective action plans. This MOU will be developed utilizing information obtained during the audits with the intent of having signed agreements with all counties/cities.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue compliance oversight to preserve and improve the overall health and well-being of these vulnerable populations.

3.13.3 Rationale

Enhancing monitoring and oversight will eliminate disparities in care to beneficiaries and reduce vulnerabilities to the state, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

3.13.4 Proposed Timeline

- **Phase I: August 2020 – June 2021**
    - Review of current standards, policies, and guidelines

  - Development of goals, performance measures, and metrics
  - Revision of current Plan and Fiscal Guidelines guidance document
  - Continuation of the establishment of an electronic submission portal for the annual county/city budgets.

- **Phase II: July - September 2021**
  - Development of auditing tools

- **Phase III: October 2021 – September 2022**
  - Shift to an electronic automated PFG submission by the counties/cities
  - Develop training documents
  - Evaluate and analyze findings and trends
  - Identify gaps and vulnerabilities

- **Phase IV: October 2022- Ongoing**
  - Initiate Memorandum of Understanding between State and counties
  - Continuous monitoring and oversight
  - Continuous updates to standards, policies, and guidelines

3.14 Improving Beneficiary Contact and Demographic Information

3.14.1 Background

Medi-Cal has approximately 13 million enrolled beneficiaries; approximately 80 percent are enrolled in the managed care delivery system and 20 percent are enrolled in the fee-for-service delivery system. County social services departments are delegated by DHCS to process Medi-Cal applications and renewals, as well as to generally provide case management services. Counties use Statewide Automated Welfare Systems (SAWS_ to support and maintain Medi-Cal enrollment processes. The SAWS, of which there are currently three, contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the state-level eligibility and enrollment system (California Healthcare Eligibility, Enrollment, and Retention System) and the state-level eligibility database, the Medi-Cal Eligibility Data System. The Medi-Cal Eligibility Data System is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things.

When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible

for ensuring the data maintained in the local county eligibility system is accurate and up to date. Under current state law, Medi-Cal managed care plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.

Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal fee-for-service providers and Medi-Cal managed care plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.

Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, it is critical that DHCS, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

3.14.2 Proposal

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services program, Medi-Cal beneficiaries, managed care plans, and the provider community.

3.14.3 Rationale

As DHCS seeks to make improvements in its approach to population-based health care and drive innovation in health care delivery, it is critical that our Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for beneficiaries. County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

3.14.4 Proposed Timeline

DHCS proposes to engage with key partners during 2022-23 to develop thoughtful and realistic recommendations for implementing improvements in how contact and demographic information can be updated by other entities in addition to county eligibility

workers. Such changes may be effectuated through updates to the Medi-Cal application, use of eligibility online portals and/or other means. As part of the workgroup effort, DHCS will also seek input in terms of timing of implementation, taking into consideration current system migrations, consolidations and/or modernization efforts.

4. Conclusion

DHCS developed these CalAIM proposals with a view toward the future and what will be necessary to more effectively and positively impact Medi-Cal beneficiaries' quality of life. These proposals were drawn from more than a year-long effort by DHCS leadership and staff, as well as engagement with critical partners and experts across the State and the nation. These ambitious proposals represent a long-term vision for advancing and improving the Medi-Cal program in fundamental ways that build upon the foundations established in prior waivers and expansion efforts. The success of the thinking behind CalAIM will fundamentally rest on the collaboration and coordination of DHCS, our plan, provider, county, and legislative partners, and the entire stakeholder community. DHCS recognizes that these proposals will likely require significant time and fiscal investment and look forward to working with our partners and through the budget process to most effectively implement the concepts proposed in this initiative. These efforts are not limited to a single year, but represent DHCS' current vision for what Medi-Cal might be able to achieve over the next five to ten years, and beyond.

5. From Medi-Cal 2020 to CalAIM: A Crosswalk

California is embarking on a new and system-wide initiative to transform how beneficiaries' access Medi-Cal services. As the Medi-Cal program has expanded under the Affordable Care Act and through other state-led initiatives, and with over 80% of beneficiaries now being served through managed care plans, it is an opportune time to consider the patient experience from an even more global perspective. Currently, beneficiaries may need to access six or more separate delivery systems (managed care, fee-for-service, specialty mental health, substance use disorder, dental, In Home Supportive Services, etc.) in order to receive the care they need. This combination of system fragmentation and clinical complexity, and the likelihood of decreased beneficiary capacity, makes access to effective care coordination even more critical.

As such, the state is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS, in recent

guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

In the spring of 2020, in response to the COVID-19 public health emergency, DHCS determined that additional time would be needed to prepare Medi-Cal managed care plans, counties, and a wide array of stakeholders for the transition from the Section 1115 waiver to the CalAIM structure. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

The following table outlines the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements:

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals				
Medi-Cal 2020 Waiver Component	**Included in Waiver Extension Through 12/31/21**	**Planned for CalAIM**	**Description**	**Timeline**
Medi-Cal Managed Care	X	Transition to new 1915(b) waiver.	The general authority for various Medi-Cal managed care will be shifted from 1115 to 1915(b). This would include PACE models needing waiver approval and Whole Child Model.	January 1, 2022
Whole Person Care Pilots	X	Transition to new 1915(b) waiver and managed care plan contract authority.	Medi-Cal managed care plans would provide a new enhanced care management benefit. Additionally, Medi-Cal managed care plans will have the option to provide a menu of approved in lieu of services. The majority of Whole Person Care services will continue to be available as both enhanced care management and in lieu of services via Medi-Cal managed care plans, and ultimately will be expanded to Medi-Cal managed care plans in non-Whole Person Care counties.	January 1, 2022
PRIME		Transition to managed care directed payment under the Quality Incentive Pool (QIP) Program.	The existing PRIME funding structure was transitioned into QIP directed payments effective July 1, 2020. Network Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs) will have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal managed care plans for reporting on a set of quality improvement measures through the QIP program.	Phase I: July 1 – December 31, 2020 Phase II: January 1, 2021
Health Homes Program	X	Transition to new 1915(b) waiver as Enhanced Care Management.	Medi-Cal managed care plans would provide a new enhanced care management benefit similar to the benefits included in the Health Homes Program. Medi-Cal managed care plans will have the option of providing a menu of approved in lieu of services. Services currently provided to populations with complex health needs under the HHP will become available under the managed care delivery system structure.	January 1, 2022

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Coordinated Care Initiative and Cal MediConnect	X	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	Transition to standardized mandatory enrollment of dual eligibles into Medi-Cal managed care plans. Multipurpose Senior Services Programs will be carved out; long-term care will be carved in statewide. All Medi-Cal managed care plans will be required to offer coverage through D-SNPs for care coordination and integration of benefits.	CCI program with end date of December 31, 2022
Drug Medi-Cal Organized Delivery System (DMC-ODS)	X	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care for substance use disorder treatment.	Implementation continues January 1, 2022
Global Payment Program	X	1115 waiver renewal.	Continuation of existing program, with discontinuation of Safety Net Care Pool funds, using only Medicaid Disproportionate Share Hospital (DSH) allotment funds.	January 1, 2022.

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Dental Transformation Initiative	X	Transition authority to Medi-Cal State Plan.	New dental benefits and provider payments: • Caries Risk Assessment Bundle for ages 0-6; • Silver Diamine Fluoride for ages 0-6, and specified high-risk and institutional populations Pay for Performance incentives for preventive services and establishing continuity of care through dental homes	January 1, 2022
Community-Based Adult Services (CBAS)	X	1115 waiver renewal.	Services for eligible older adults and those with disabilities to restore or maintain their optimal capacity for self-care. The goal is to delay or prevent inappropriate or personally undesirable institutionalization.	January 1, 2022
Eligibility Authorities	X	1115 waiver renewal.	Full Scope Benefit for Pregnancy Related Beneficiaries with FPL 109-138% and Out of State Former Foster Care Youth.	January 1, 2022
Rady CCS Pilot	X	Not included.	The demonstration project tested two healthcare delivery models for children enrolled in the California Children's Services (CCS) Program.	Expires December 31, 2021
Designated State Health Programs (DSHP)	X	Not included.	Financing mechanism under 1115 waiver which has permitted federal funding for certain State health programs not traditionally allowed for federal funding	Expires December 31, 2020
Tribal Uncompensated Care	X	Not included.	The state makes supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care. DHCS will work to implement Tribal FQHCs by January 1, 2021, which will account for the remaining services being billed for under Tribal Uncompensated Care.	Expires December 31, 2021

5.1 Transition of PRIME to Quality Incentive Program

5.1.1 Background

The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program built on other delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals and 34 District and Municipal Public Hospitals participated in PRIME. PRIME was designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a Quality Incentive Program (QIP) – a managed care directed payment program – for the state's Designated Public Hospitals. The state directs Medi-Cal managed care plans to make QIP payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The QIP promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The QIP also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the state to pay for quality and build capacity.

5.1.2 Proposal

DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP and permitting the District and Municipal Public Hospitals to begin participating in the program, which has enabled hospitals to continue quality improvement efforts underway at all 51 PRIME entities after PRIME expired on June 30, 2020. This transition promotes value-based purchasing, ties funding to quality outcomes, and aligns PRIME entities' transition to the QIP with California's transition to the calendar year rating period for Medi-Cal managed care plans.

There are two key phases in the PRIME-to- QIP transition:

- **Phase I:** Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020

- **Phase II:** Merge to QIP, January 1, 2021 through December 2021, and beyond.

Phase I: Alignment with Calendar Year Rating Period

All 51 PRIME entities transitioned into a six-month transitional program on July 1, 2020 to calibrates the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for Medi-Cal managed care plans that ended on December 31, 2020. For performance on both the original QIP quality metrics (for Designated Public Hospitals) and the PRIME transition metrics (for Designated Public Hospitals and 34 District and Municipal Public Hospitals) during this period, the 51 entities will be paid through Medi-Cal managed care plans, via state-directed Medi-Cal managed care plan payments. CMS approval for this six-month program was obtained on September 14, 2020.

To earn funds for PRIME transition metrics, all 51 PRIME entities will continue to report to DHCS on quality improvement projects and measures from PRIME. The six-month transition will use a twelve-month measurement period to ensure that performance can be fairly compared to benchmarks set by DHCS. Due to the COVID-19 public health emergency, entities will use the March 1, 2019 to February 29, 2020 measurement period and be held to achieving the minimum performance benchmark established by DHCS from PRIME Demonstration Year 15. The Designated Public Hospitals will also continue activities on the original QIP quality metrics during this six-month period, utilizing the same modifications due to the COVID-19 public health emergency outlined for PRIME above.

Phase II: Merge to QIP

Subject to obtaining the necessary federal approvals, January 1, 2021 will be the start of QIP Year 4 and will include the Designated Public Hospitals and 34 District and Municipal Public Hospitals, totaling 51 QIP entities. Similar to Phase I, payments to the 51 QIP entities will be directed payments through the Medi-Cal managed care plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to QIP. DHCS will review all prior PRIME Policy Letters and QIP Policy Letters for relevance and issue updated Policy Letters and reporting guidance to Designated Public Hospitals and District and Municipal Public Hospitals.

DHCS worked with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, other nationally vetted and endorsed measures, and measures in wide use across Medicaid quality initiatives. The measures align with well-established benchmarks and State, Medi-Cal managed care plan, and hospital system goals. The Program Year 4 metric set meaningfully reflects the goals and priorities of CalAIM.

5.1.3 Rationale

The QIP Program is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The PRIME to QIP transition will engage both Designated Public Hospitals and 34 District and Municipal Public Hospitals to continue quality improvement work for select priority metrics in QIP As such, this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across Designated Public Hospitals and District and Municipal Public Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through alignment of quality measures with those required of health plans.

5.1.4 Proposed Timeline

January 1, 2021: Complete transition from PRIME to QIP for Designated Public Hospitals and District and Municipal Public Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures

5.2 Global Payment Program Extension

5.2.1 Background

The Global Payment Program is a five-year pilot program included in California's Medi-Cal 2020 Section 1115 demonstration waiver. The Global Payment Program establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital (DSH) allotment with available uncompensated care funding. These funds support public health care system efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured.

Global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting.

The Global Payment Program's requirements are established in the Special Terms and Conditions for California's Medi-Cal 2020 Section 1115 demonstration and the program

funding is authorized December 31, 2021 under the one year Medi-Cal 2020 extension proposal, submitted to CMS on September 16, 2020.

5.2.2 Proposal

DHCS proposes to extend the Global Payment Program under CalAIM through a renewal of the Medi-Cal Section 1115 waiver demonstration. The Global Payment Program will operate under the following assumptions:

- The start date of Program Year 7 will begin on January 1, 2022, and end on December 31, 2022. The Global Payment Program was originally approved through June 30, 2020. On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a waiver amendment extending the program and authorizing Program Year 6A for the period of July 1, 2020 through December 31, 2020. The Medi-Cal 2020 one-year extension proposal extended the program through December 31, 2021.
- The Global Payment Program under CalAIM will be funded solely by a portion of the State's Designated Public Hospital Disproportionate Share Hospital allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of Designated Public Hospital Disproportionate Share Hospital allotment funds to be split amongst University of California hospitals and Global Payment Program public health care systems will remain constant for the entirety of the waiver with 78.104% allocated to the Global Payment Program and 21.896% allocated to University of California hospitals;
- The Global Payment Program will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The Global Payment Program will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS may recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the Global Payment Program in the CalAIM period will operate per the Medi-Cal 2020 waiver Special Terms and Conditions.

5.2.3 Rationale

The Global Payment Program was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public healthcare systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and
- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay.

DHCS collaborated with the RAND Corporation to conduct an evaluation of the Global Payment Program from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings.

These findings provide strong support for the argument that the Global Payment Program is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to the State's remaining uninsured individuals and will continue to move in this direction over the next five years.

5.2.4 Proposed Timeline

DHCS proposes to extend the Global Payment Program for the next five years according to the schedule in **Attachment G.**

6. Appendices

Appendix A: 2021 and Beyond: CalAIM Implementation Timeline[3]

Date	Implementation Activity
July 1, 2020	**PRIME transitions to Quality Incentive Program**
January 1, 2021	12-month extension of Medi-Cal 2020 demonstration
April 2021	**Submission of Section 1915(b) and 1115 waiver requests** **Pharmacy Carve-Out Effective**
June 2021	**County Oversight[4]:** DHCS will engage with counties by forming a working group that will focus on developing new county performance standards monitoring and reporting mechanism. The reinstatement of County Performance Standards will include incorporation of MEDS alert monitoring statewide **County oversight (CCS, CHDP):** Development of auditing tools. **Foster Care Model of Care Workgroup** completed
October 2021	**County oversight (CCS, CHDP):** Shift to automated Plan and Fiscal Guideline submission process, develop training documents, evaluate and analyze findings and trends, and identify gaps and vulnerabilities.
November-2021	**County Inmate Pre-Release Application Process:** Stakeholder process
December 2021	**County Oversight**: DHCS will publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CPAs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties. **Goal approval date of Section 1915(b) and 1115 waiver requests**
2022	

[3] Implementation date TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

[4] Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

Date	Implementation Activity
January 1, 2022	**Managed Care Authority:** Shifts to 1915(b) authority **Implementation of the following CalAIM proposals:** • Enhanced care management/In lieu of services (existing WPC and/ or HHP target populations) • Incentive payments • Dental benefits and pay for performance (implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration) • Managed care benefit standardization continues • Mandatory managed care • Regional Rates Phase I • DMC-ODS renewal and policy improvements • Changes to behavioral health medical necessity • Multipurpose Senior Services Program carved-out of managed care • D-SNP look-alike enrollment transition in CCI counties **County Inmate Pre-Release Application Process:** Publication of guidance and begin Technical Assistance (through December 2022)
March 2022	**County Oversight**: DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.
June 2022	**County Oversight**: DHCS will implement the County Performance Monitoring Dashboard. The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.
July 2022	**Behavioral Health Payment Reform** **Enhanced care management:** • Implementation of additional enhanced care management Target Populations in HHP/WPC Counties. • Managed care plans in non- WPC and/or HHP counties begin implementing enhanced care management target populations
September 2022	**County Oversight**: DHCS will begin publishing the County Performance Monitoring Dashboard on the CHHS Open Data Portal.
October 2022	**County oversight (CCS, CHDP):** Initiate Memorandum of Understanding between State and counties, continuous monitoring and oversight, and continuous updates to standards, policies, and guidelines
December 31, 2022	**Cal MediConnect:** End of program
2023	
January 2023	**Aligned Enrollment:**

Date	Implementation Activity
	• Require statewide mandatory enrollment of dual eligibles in Medi-Cal managed care[5] • All Medi-Cal health plans in CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan, including dual eligible LTC residents • Require statewide mandatory enrollment for eligible LTC residents for both non-dual and dual beneficiaries **County Inmate Pre-Release Application Process:** Implementation **Shared Risk/Shared Savings** (at the earliest) **Enhanced care management:** Implementation of all enhanced care management target populations, including Individuals Transitioning from Incarceration.
December 2023	**County Oversight**: DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.
2024	
January 2024	**Regional Rates, Phase II** (at the earliest)
2025	
January 2025	**Aligned Enrollment:** • All Medi-Cal health plans in non-CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as a Medi-Cal managed care plan.
2026	
January 2026	**NCQA:** All Medi-Cal managed care plans required to be NCQA accredited
2027	
January 2027	**Behavioral Health Administrative Integration:** submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver **Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans:** Full implementation **Full Integration Plan:** Go Live (no sooner than)

[5] Mandatory Managed Care enrollment: See **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage.**

Appendix B: Targeted Case Management

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X		
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County				X		
Kings County						X
Lake County						X
Lassen County						X
Los Angeles County	X			X		

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County	X	X	X	X	X	
Merced County						X
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X	X	X	X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County				X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	
San Francisco County						X
San Joaquin County						X

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Luis Obispo County	X	X		X		
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X	X	
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X	X	
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**24**	**16**	**30**	**15**	**30**

Appendix C: County Inmate Pre-Release Application Process sample contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

Appendix D: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones

Below is a summary of demonstration goals as outlined in CMS SMD Letter #18-011:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Below is a summary of demonstration milestones as outlined in CMS SMD Letter #18-011:

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;
- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;
- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's

capacity to track available beds, and implementation of an evidence-based assessment tool; and

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application;

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- Specifically, CMS requests that states' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;

- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- Written documentation of the state's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.
- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.
- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a $5 million deferral per deliverable.

Key Resources

- State Medicaid Director Letter #18-011: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
- Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity Technical Assistance Questions & Answers: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf

Appendix E: CalAIM Benefit Changes Chart

Benefit Changes Effective April 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Pharmacy	All pharmacy benefits or services billed by a pharmacy on a pharmacy claim, which includes covered outpatient drugs (including Physician Administered Drugs), medical supplies, and enteral nutrition products. This also includes drugs currently "carved-out" of the managed care delivery system, (e.g., blood factor, HIV/AIDS, antipsychotics, and drugs used to treat substance use disorder), which are currently carved-in to some county operated health systems and AIDS Healthcare Foundation. This does not include any pharmacy benefits or services billed on medical and/or institutional claims.
Benefit Changes Effective January 1, 2022	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)
Benefits to be Carved-In to Managed Care Statewide	
Major Organ Transplant	Currently full benefit in county operated health systems counties; non-county operated health systems counties currently only cover kidney transplants
Benefit Changes Effective January 1, 2023	
Benefits to be Carved-In to Managed Care Statewide	
Long Term Care	Long Term Care Umbrella • ICF-DD Disabled (excluding beneficiaries in an ICF-DD Waiver center), Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • Skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services Currently full benefit in county operated health systems and CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside); in non-county operated health systems/non-CCI counties, Medi-Cal managed care plans are responsible for the month of admission and the month following

Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

[6] Members residing in a LTC facility in a non-LTC aid code subject to the LTC benefit carve-in will be transitioned into managed care based on the Non-Dual/Dual Mandatory and Voluntary timeline.
[7] Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A **or** Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A **and** Part B or Medicare Part A, B, and D.
[8] Aid code can have a SOC or no SOC

Managed Care Enrollment												
Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Aged	10[9], 14, 16, 1E, 1H, 1X, 1Y	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, K4, K8, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Non-Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U,	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A

[9] Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.

Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L										
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	58	Non-Dual	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82 ,83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 83, 2C, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 5E, 6P,	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A

Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	7A, 7J, 7T, 7W, 7X, 8P, 8R, 9H, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5										
Aged	10[2], 14, 16, 1E, 1H, 1X, 1Y	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, L6, K4, K8	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment												
Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Presumptive Eligibility (Hospital and CHDP PE)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming	8U, 8V	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3,K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 53, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0R, 0T, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G,	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	Aid Codes[6]	Non-Dual/ Dual[7]	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9										

Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				**Non-Citizen**		
	Aid Codes	**Current**	**Proposed (2021)**		**Aid Codes**	**Current**	**Proposed (2021)**
Title XXI (SCHIP) 213-322%	86, 87, 0E	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	**Current**			**2022**			**2023**		
	Mandatory	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
American Indian[10]	COHS	Non-COHS	N/A	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Rural Zip Codes[12]	COHS	Non-COHS	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models[11]	N/A	N/A

[10] American Indian Beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS
[11] Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment
[12] The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

Appendix G: Global Payment Program Extension Timeline

Program Year	Calendar Year	Federal Fiscal Year	Service Period Dates
6[13]	2021	2021	January 1, 2021-December 31, 2021
7	2022	2022	January 1, 2022 – December 31, 2022
8	2023	2023	January 1, 2023 – December 31, 2023
9	2024	2024	January 1, 2024 – December 31, 2024
10	2025	2025	January 1, 2025 – December 31, 2025
11	2026	2026	January 1, 2026 – December 31, 2026

[13] *PY 6 is part of Medi-Cal 2020 demonstration extension through 12/31/21*

Appendix H: Dental in Proposition 56 vs. CalAIM

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D0120	Periodic oral evaluation – established patient	No	Yes
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No	Yes
D0150	Comprehensive oral evaluation – new or established patient	No	Yes
D0601	Caries risk assessment and documentation, with a finding of low risk (children ages 0-6)	No	Yes
D0602	Caries risk assessment and documentation, with a finding of moderate risk (children ages 0-6)	No	Yes
D0603	Caries risk assessment and documentation, with a finding of high-risk (children ages 0-6)	No	Yes
D1110	Prophylaxis – adult	Yes	No
D1120	Prophylaxis - child	No	Yes
D1206	Topical application of fluoride varnish (child)	No	Yes
	Topical application of fluoride varnish (adult)	Yes	No
D1208	Topical application of fluoride – excluding varnish (child)	No	Yes
	Topical application of fluoride – excluding varnish (adult)	Yes	No
D1310	Nutritional counseling for the control of dental disease (child)	No	Yes

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D1320	Tobacco counseling for the control and prevention of oral disease (adult)	No	Yes
D1351	Sealant – per tooth (child)	No	Yes
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (child)	No	Yes
D1354	Interim caries arresting medicament application – per tooth (children ages 0-6 and restricted adult populations)	No	Yes
D1510	Space maintainer – fixed, unilateral – per quadrant (child)	No	Yes
D1516	Space maintainer – fixed, bilateral, maxillary (child)	No	Yes
D1517	Space maintainer – fixed, bilateral, mandibular (child)	No	Yes
D1526	Space maintainer – removable, bilateral, maxillary (child)	No	Yes
D1527	Space maintainer – removable, bilateral, mandibular (child)	No	Yes
D1551	Re-cement or re-bond space maintainer – bilateral space maintainer, maxillary (child)	No	Yes
D1552	Re-cement or re-bond space maintainer – bilateral space maintainer, mandibular (child)	No	Yes
D1553	Re-cement or re-bond space maintainer – unilateral space maintainer – per quadrant (child)	No	Yes
D1556	Removal of fixed unilateral space maintainer – per quadrant (child)	No	Yes
D1557	Removal of fixed bilateral space maintainer – maxillary (child)	No	Yes
D1558	Removal of fixed bilateral space maintainer – mandibular (child)	No	Yes
D1575	Distal shoe space maintainer – fixed unilateral – per quadrant (child)	No	Yes
D1999	Unspecified preventive procedure, by report (adult)	No	Yes

Appendix I: Enhanced Care Management Target Population Descriptions

Enhanced care management is designed for populations who have the highest levels of complex health care needs as well as social factors influencing their health. To be eligible for enhanced care management, members must meet criteria below in addition to any criteria specific to the respective enhanced care management population:

1. Have complex physical or behavioral health condition with inability to successfully self-manage AND
2. Limited activity or participation in social functioning as defined by at least one of the following:
    a. Establishing and managing relationships;
    b. Major life areas, including education, employment, finances, engaging in the community

Candidates for enhanced care management have an opportunity for improved health outcomes if they receive high-touch, in-person care management and are connected to a multidisciplinary team that manages physical health, behavioral health (substance use and/or mental health), oral health, developmental disabilities, and health-related non-clinical needs as well as any needed long-term services and supports.

Enhanced care management will be implemented in phases:

- January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.
- July 1, 2022:
    - Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
    - All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.
- January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Characteristics of ECM target populations are set forth below and detailed further in this document. Risk stratification is the responsibility of the Medi-Cal managed care plans,

which will determine member needs and apply criteria to determine eligibility and facilitate ECM services. Medi-Cal managed care plans may propose additional populations to receive ECM or propose expansions of criteria within populations. ECM target populations are subject to further refinement by DHCS.

Medi-Cal managed care plans may propose additional populations to receive enhanced care management, for example to allow the transition for members receiving services under a Whole Person Care pilot. At a minimum, Medi-Cal managed care plans must provide enhanced care management to the below list of mandatory target populations:[14]

- Children and youth with complex physical, behavioral, and/or developmental health needs (i.e. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization, eligible for long-term care.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children and youth with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD).
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

These target population descriptions are intended as guidance for Medi-Cal managed care plans. Managed care plans will determine criteria for population identification and stratification in accordance with this guidance.

Settings

For all populations, the role of enhanced care management is to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the

[14] Individuals transitioning from incarceration must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

member, including participating in the care planning process, regardless of setting. This benefit is intended to provide primarily face-to-face services whenever possible.

Services should be offered where the members live, seek care or prefer to access services, essentially meeting the member (and, for children and youth, their family, caretaker or circle of support) where they are within the community. This may include different settings based on the target population. For example, for individuals experiencing homelessness, enhanced care management care managers may conduct street outreach or coordinate with shelters, hotels or motels including those participating in Project Homekey, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals in these settings. For individuals with SMI and/or SUDs, initial contact may be in settings such as psychiatric inpatient units, Institutions for Mental Disease (IMDs) or residential settings. Children and youth may receive services in a variety of community settings, including homes and schools, where appropriate. These are examples of how enhanced care management settings will reflect individualized needs of the target populations.

Risk Stratification

Enhanced care management is the highest tier of case management and is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems. As part of their plan submitted to DHCS, Medi-Cal managed care plans will detail the algorithms, processes, and partnerships they will use to identify those individuals who have the highest levels of complex health care needs and social factors influencing their health, and who present the best opportunity for improved health outcomes through enhanced care management services.

Algorithms and data sources may vary by population. For example, some individuals may be identified using claims data and/or other health assessment information to identify multiple complex conditions or a history of utilization of high-cost services.

However, for a variety of reasons, claims data may be insufficient to identify other good candidates for enhanced care management. For some members, access to care issues and multiple social factors may limit the utility of claims data in identifying health risks. Therefore, managed care plans must also use data sources that capture social determinants of health as well as referrals. For individuals experiencing homelessness, data systems such as the Homeless Management Information System (HMIS) may be used. For individuals transitioning from incarceration, data sharing agreements with city and county jail systems to identify those at highest risk may be considered

For many populations, referrals and partnerships will be a critical method to identify enhanced care management candidates. Entities such as health care providers, community-based organizations, social services agencies, tribal partners, and local governments are important partners in identifying individuals who are at high risk of significant health care utilization and who would benefit from enhanced care management. Medi-Cal managed care plans are encouraged to partner with these entities to ensure enhanced care management benefits are highly coordinated with other service types. Medi-Cal managed care plans should also plan to establish clear protocols to receive and consider enhanced care management referrals from external entities.

Core Components of Enhanced Care Management Services

The types of supports and services provided through enhanced care management may vary based on the needs of the target populations. In the individual target population descriptions, this document describes examples of interventions that enhanced care management may support for each unique target population. However, core components of enhanced care management that are universal for all target populations include:

- Comprehensive Assessment and Care Management Plan:
    - Engage with Members authorized to receive the enhanced care management Benefit primarily through in person contact;
        - *When in-person communication is unavailable or does not meet the needs of the Member, use alternative methods to provide culturally appropriate and accessible communication.*
    - Develop a comprehensive, individualized, person-centered care plan by working with the Member, and as appropriate their chosen family/support persons, to assess strengths, risks, needs, goals, and preferences
    - Incorporate into the Member's care plan needs in the areas including, but not limited to physical and developmental health, mental health, SUD, community-based Long-Term Services and Supports (LTSS), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing;
    - Ensure the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in need.
- Enhanced Coordination of Care:
    - Organize patient care activities as laid out in the care plan, share information with the Member's key care team, and implement the Member's care plan;

- Be continuous and integrated among all service providers and refer to primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, and, housing, as needed;
- Provide support for Member treatment adherence including coordination for medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, identifying barriers to adherence, ensuring continuous enrollment in Medi-Cal, and maintaining social services benefits, and accompaniment to key appointments;
- Communicate Members' needs and preferences timely to all members of the Members' care team in a manner that ensures safe, appropriate, and effective person-centered care;
- Be in regular contact with the Member, consistent with the care plan;

- Health Promotion:
  - Work with Members to identify and build on resiliencies and potential family or community supports;
  - Provide services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health;
  - Support the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- Comprehensive Transitional Care
  - Perform engagement activities that seek to reduce avoidable Member admissions and readmissions;
  - For Members that are experiencing or are likely to experience a care transition:
    - Develop and regularly update a transition plan for the Member, and incorporate it into the Member's care plan;
    - Evaluate a Member's medical care needs and coordination of any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

- Track each Member's admission or discharge to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicate with the appropriate care team members;
- Coordinate medication review/reconciliation; and
- Provide adherence support and referral to appropriate services.

- Member and Family Supports:
  - Document a Member's chosen caregiver or family/support person;
  - Include activities that ensure that the Member and chosen family/support persons, including as guardians and caregivers, are knowledgeable about the Member's condition(s) and care plan with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management;
  - Serve as the primary point of contact for the Member and their chosen family/support persons;
  - Identify supports needed for the Member and chosen family/support persons to manage the Member's condition and direct them to access needed support services, including peer supports when applicable and available; and,
  - Provide for appropriate education of the Member, family members, guardians, and caregivers on care instructions for the Member.
- Coordination of and Referral to Community and Social Support Services:
  - Determine appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services that are offered by managed care plan as an ILOS;
  - Coordinate and referring Members to available community resources and following up with Members to ensure services were rendered (i.e. "Closed loop referrals").

Target Populations

A description of each population is outlined below. Beneficiaries must be enrolled in Medi-Cal managed care to receive enhanced care management. In general, for all target populations, individuals who, after multiple outreach attempts, using different modalities, opt not to participate in enhanced care management services or whose assessment

(completed or confirmed by the managed care plan) indicates they would not benefit from the services, would not be good candidates for enhanced care management. The number of outreach attempts and approaches will vary based on the populations and individualized needs.

Enhanced care management is designed to provide support to individuals who require high levels of intensive interventions. Individuals who are receiving or who would benefit from other existing types of interventions (e.g., end of life care, standard case management, disease management or other care coordination efforts) would not be appropriate candidates for enhanced care management unless those interventions are not successful. Medi-Cal managed care plans and/or their subcontractors or contracted providers will evaluate individuals for enhanced care management and not all individuals will be good candidates. For example, individuals with the following circumstances may not be good candidates for enhanced care management:

- Individuals who have a well-treated chronic disease and are compliant with their care plan and have unavoidable or expected admissions due to the condition.
- Individuals who refuse to engage in any telephonic or face to face case management after multiple outreach attempts using different modalities.
- Individuals receiving services that the managed care plan determines to be duplicative of enhanced care management, such as 1915(c) Home and Community Based Services (HCBS) Waiver programs.

All Medi-Cal beneficiaries currently receiving care management through the Health Homes Program and Whole Person Care shall be transitioned to enhanced care management through one of the target populations listed and will be reassessed.

The populations eligible for enhanced care management are those with the highest needs who use multiple delivery systems and services, who need ongoing coordination across medical, behavioral and social needs, and who are part of the mandatory target populations described below. Note that some enhanced care management candidates will meet criteria for multiple target populations. Medi-Cal managed care plans will assign these individuals authorized to receive enhanced care management services to an enhanced care management provider that has appropriate competencies and experience for the needs of the beneficiary. For example, individuals with SMI or SUDs may also be homeless or high utilizers. These members may be assigned to an enhanced care management provider that has the necessary skills and experience to work with individuals with SMI and SUDs.

Children and Youth

Target Population:

Children and youth (up to age 21, or foster youth to age 26) with complex physical, behavioral, and/or developmental health needs, with significant functional limitations and social factors influencing their health outcomes (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).

For example:

- Children/Youth with complex health needs who are medically fragile or have multiple chronic conditions. This may include children with a history of trauma and children who are engaged or have history with the child welfare system. These children often access care across multiple service delivery systems and require significant coordination to ensure their needs are being met.

- Children/Youth with significant functional limitations and multiple social factors influencing their health outcomes.

Enhanced Care Management Services:

Enhanced care management can be used to assess gaps in both health care and social support needs and develop a care plan that addresses the whole health needs of the child. While Medi-Cal managed care plans may use claims data to identify good candidates, referrals will be an important mechanism to identify children and youth who would benefit from enhanced care management. Health care providers, the child welfare system, schools, community-based organizations, California Children's Services (CCS), county behavioral health, and social services agencies are examples of other important potential referral partners for children/youth. Medi-Cal managed care plans should establish a process for providers to refer for enhanced care management based on a needs assessment, behavioral health screens, other EPSDT screening, and/or ACE score which includes consideration of the community supports available for the children and their families and caretakers, as well as social factors impacting their health.

Services should be offered where the members live, seek care or where the family, caretaker, or circle of support prefers to access services, essentially meeting the member and family/caretaker/support where they are within the community. Activities may include coordination in school-based settings if permitted by the schools. Services should be offered by culturally and linguistically aligned trauma-informed providers.

For this population, enhanced care management services include (but are not limited to):

- Helping families, caretakers, and circles of support access resources such as information, coordination, and education about the child's conditions.
- Identifying coordinating, and providing (when appropriate) services that will help families, caretakers, and circles of support with the health needs of their children, which may include referrals for services those individuals need to enable them to support their children's health (e.g., referral to behavioral health, including SUD services, for a parent, or housing-related services for households experiencing homelessness, either of which could be critical to ensure the parent can support the health needs of the child).
- Referral to housing related services for youth experiencing homelessness.
- Coordination of services across various health, behavioral health, developmental disability, housing and social services providers, including facilitating cross-provider data- and information-sharing and member advocacy to ensure the child's whole person needs are met and needed services are accessible.
- Assistance with accessing respite care as needed.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health.
- Coordination of other services as required by EPSDT.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health

Homeless

Target Population:

Individuals experiencing homelessness or chronic homelessness, or who are at risk of experiencing homelessness (as defined below), with complex health and/or behavioral health needs, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.

For example:

- Individuals with complex health care needs as a result of medical, psychiatric or SUD-related conditions, who may also experience access to care issues (resulting in unmet needs or barriers to care) and multiple social factors influencing their health outcomes.
- Individuals with repeated incidents of avoidable justice involvement, emergency department use, psychiatric emergency services or hospitalizations.

Homeless: Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution). For the purpose of enhanced care management, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

A. In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who meet the State’s No Place Like Home definition for a person with SMI and/or SED “at risk of chronic homelessness,” which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with

significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Enhanced Care Management Services:

Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. Individuals often have high medical needs that are difficult to manage due to the social factors that influence the individual's health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals.[15] As individuals are connected to resources, the enhanced care management care coordinator will meet the member in the community or at provider locations.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- Utilizing housing-related in-lieu-of services (ILOS) to identify housing and prepare individuals to for securing and/or maintaining stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress towards regaining health and function continues.
- Coordinating and collaborating with various health and social services providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to

[15] These same entities will be important referral partners to identify potential enhanced care management candidates

public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.

- Addressing barriers to housing stability by connecting member to housing, health, and social support resources.
- Utilize best practices for Member who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care

High Utilizers

Target Population:

High utilizers are Members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence.

For example:

- Individuals that have impactable conditions or opportunities for interventions that have the potential to decrease inappropriate utilization or can be performed at an alternative location.
- Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement. Individuals with multiple chronic or poorly managed conditions requiring intensive coordination, beyond telephonic intervention.
- Significant functional limitations and/or adverse social determinant of health that impede the ability of the individual to navigate their healthcare and other services.

Enhanced Care Management Services:

Enhanced care management will provide multiple opportunities to engage individuals by stratifying risk and need and developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Medi-Cal managed care plans will identify the algorithms they will use to identify individuals who are high utilizers of medical services. DHCS expects Medi-Cal managed care plans will rely on available healthcare research related to appropriate identification of high utilizers and will leverage the managed care plan utilization data to identify members that meet the respective criteria established by the managed care plans.

For this population enhanced care management may include, but is not limited to:

- Frequent follow up visits, culturally and linguistically appropriate education and care coordination activities to ensure the member's needs are being met where they are.
- Connection to culturally and linguistically appropriate community-based organizations, programs and resources that will meet the member's needs.
- Improving member engagement to improve adherence to the member's treatment plan, including through more culturally and linguistically aligned approaches toward member and provider education and tools on how to increase adherence.

- Medication review, reconciliation, assistance obtaining medications, and culturally and linguistically appropriate reinforcement with medication adherence.

Risk for Institutionalization – Long Term Care

Target Population:

Individuals at risk for institutionalization, eligible for long-term care services. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) would qualify.

Individuals must meet NF level of care criteria AND be able continue to live safely in the community with wrap around supports. \

Examples include, but are not limited to:

- Seniors and persons with disabilities who reside in the community but are at risk of being institutionalized.
- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive, or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Would not include:

- Individuals with complex needs but who are not at risk of institutionalization.

Enhanced Care Management Services:

Services include preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. For this population enhanced care management may include, but is not limited to:

- Assessment to determine natural supports available, risk factors, social determinants of health, and other factors to determine safety and feasibility of continued stay in the community. Assessments should be conducted face-to-face whenever possible.
- Connection to needed supportive services, including ILOS such as meals, environmental accessibility adaptations (home modifications), and personal care.
- Frequent follow up visits (including regular home visits), culturally and linguistically appropriate education and care coordination activities to ensure the member and family/caregiver needs are being met where they are.
- Connection to appropriate culturally and linguistically aligned community-based organizations, programs and resources that will meet the member's needs.
- Placement of wrap-around services to maintain the member in their current, community setting.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, ensuring connection to public benefits, coordinating transportation, identifying barriers to adherence, and accompanying members to appointments as needed.

Nursing Facility Transition to Community

Target Population:

Individuals who are currently residing in a Nursing Facility (NF) but desire to return to living in the community. Transition from the NF to community is strictly voluntary. Individuals have the option to transition to the community when that can be done in a cost-effective manner. Individuals must be able to transition safely to the community.

Individuals must have an identified support network system and housing available to them. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parent, or any other individual who is part of

the individual's circle of support. The individual's circle of support may consist of family members, legal representative/legally responsible adult, and any other person named by the individual.

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are not medically appropriate to live in the community (high acuity).
- Individuals whose total projected costs outside the institution are greater than the cost of institutionalization.
- Individuals who do not have the supports to reside safely in the community.
- Individuals who would be at a high risk of re-institutionalization or experiencing homelessness.

Enhanced Care Management Services:

The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility and returning to their own home.

Services include facilitating nursing facility transition back into a homelike and community setting with the necessary wrap-around services, community supports, and natural supports when available.

Enhanced Care Manager care manager visits will occur face to face at the facility throughout the transition process. An in-person home visit will occur prior to the

individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

SMI, SED and SUD Individuals at Risk for Institutionalization

Target Population:

Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and:

- Serious Mental Illness (SMI, adults);
- Serious Emotional Disturbance (SED, children, and youth); or
- Substance Use Disorder (SUD).

Potential candidates include:

- Individuals who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions with co-occurring chronic health conditions, who may also experience access to care issues and have multiple social factors influencing their health outcomes and as a result of these factors are at risk for institutionalization.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services, psychiatric inpatient hospitalizations, including stays at psychiatric health facilities, or short-term skilled nursing facility stays who could be served in community-based settings with supports.

Enhanced Care Manager Services:

For individuals with SMI or SUD, or children and youth with SED, enhanced care management will coordinate across the delivery systems through which members access care. For these individuals, Medi-Cal managed care plans may pursue contracts with county behavioral health systems to perform enhanced care management activities, but this must include coordination of all available services including medical care, behavioral health and long-term services and supports. When managed care plans do not contract with county behavioral health, enhanced care management service providers for this population should have experience and competency in working with individuals with SMI and SUDs as well as a plan to adequately coordinate enhanced care management and behavioral health services and supports across the managed care plan and county behavioral health. Initial engagement may be in treatment settings such as psychiatric inpatient units, IMDs or residential settings.

For children and youth with SED, activities may include coordination in school-based settings if permitted by the schools.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. Medi-Cal managed care plans should closely coordinate these

enhanced care management services and supports with county behavioral health to avoid duplication and ensure adequate communication and care coordination. This includes (but is not limited to):

- Provide post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization including identifying appropriate culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the hospitalization or residential treatment occurs due to mental illness or substance use disorder.

- Regular culturally and linguistically appropriate contact with members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.

- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.

- Supporting the members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.

- Connecting families, caretakers, and circles of support to resources regarding the member's conditions to assist them with providing support for the member's health/behavioral health.

- Coordinating and collaborating with various health, behavioral health, developmental disability, and social services providers including sharing data (as appropriate).

- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed

Individuals Transitioning from Incarceration[16]

Target Population:

Individuals transitioning from incarceration, including justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. A Medi-Cal managed care plan may stratify eligibility based on populations that have multiple incarcerations, other institutionalizations and/or high utilization. Individuals must have been released from incarceration with the last 12 months.

In addition, this population includes individuals who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and therefore are at risk for incarceration and who could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Enhanced Care Management Services:

Some individuals transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. Individuals often also experience significant social factors that impact their ability to successfully manage their health/behavioral health conditions, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and as a result often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

For this target population, enhanced care management requires coordination with the state prison system and local corrections departments, including probation, courts and the local county jail system to both to identify/refer members and also to ensure connections to care once individuals are released from incarceration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and managed care plans on an as needed basis. Medi-Cal managed care plans and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities. Therefore, the enhanced care management care managers will need to coordinate and

[16] This target population must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

collaborate closely with county behavioral health departments, and potentially also with Medi-Cal managed care plans, for those individuals.

The initial enhanced care management engagement locations will depend on the collaborations that Medi-Cal managed care plans are able to build with local justice partners. At first, enhanced care management staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[17] Post-transition, enhanced care management care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based engagement such as a member's home or regular provider office, this may also include parole or probation offices if the managed care plan builds partnerships that allow for engagement in those offices.

Enhanced care management can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. This includes (but is not limited to):

- Coordination of an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Direct connections with community providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to prevent reincarceration and ensure progress towards regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.

[17] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. enhanced care management dollars will not be able to be used to provide services directly to justice involved members prior to release

- Coordinating and collaborating with various health, behavioral health, and social services providers as well as parole/probation including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.
- Helping members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers, and circles of support regarding the member's health care needs and available supports.
- Navigating members to other reentry support providers to address unmet needs.
- Facilitating benefits reinstatement.[18]

[18] To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023 The enhanced care management care manager would also help facilitate accessing other benefits as needed by the member.

Enhanced Care Management Implementation Dates by County

Counties with Whole Person Care and/or Health Homes[19] (Begin implementation on 1/1/22)		Counties without Whole Person Care or Health Homes (Begin implementation on 7/1/22*)
Alameda	HHP, WPC	Alpine
Contra Costa	WPC	Amador
Imperial	HHP	Butte
Kern	HHP, WPC	Calaveras
Kings	WPC	Colusa
Los Angeles	HHP, WPC	Del Norte
Marin	WPC	El Dorado
Mendocino	WPC	Fresno
Monterey	WPC	Glenn
Napa	WPC	Humboldt
Orange	HHP, WPC	Inyo
Placer	WPC	Lake
Riverside	HHP, WPC	Lassen
Sacramento	HHP, WPC	Madera
San Bernardino	HHP, WPC	Mariposa
San Diego	HHP, WPC	Merced
San Francisco	HHP, WPC	Modoc
San Joaquin	WPC	Mono
San Mateo	WPC	Nevada
Santa Clara	HHP, WPC	Plumas
Santa Cruz	WPC	San Luis Obispo
Shasta	WPC	Santa Barbara
Sonoma	WPC	Sierra
Tulare	HHP	Siskiyou
Ventura	WPC	Solano
		Stanislaus
		Sutter
		Tehama
		Trinity
		Tuolumne
		Yolo
		Yuba

[19] List is subject to changed based on WPC pilots decisions to continue operating through 2021.

Appendix J: In Lieu of Services Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. ILOS are optional for both the plan to offer and the beneficiary to accept. Individuals do not have to be enrolled in Enhanced Care Management to be eligible for in lieu of services. ECM target populations/ILOS Service definitions are subject to further refinement by DHCS.

Each set of services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. [20]
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the client with landlords.

[20] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[21]
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted ILOS providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

[21] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            b. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months

or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

terminated within 21 days after the date of application for assistance;
- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

  - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
  - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the managed care plan contracts.

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.

Individuals may not be receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;

- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, Medi-Cal managed care plans must credential the providers as required by DHCS.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.[22]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient Hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

[22] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with

disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            c. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            d. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions

included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs. Please see housing deposits ILOS.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

- In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
- By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
    - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
        e. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
        f. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or
    - An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
    - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose

composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.

254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what

conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established

enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.[23]

This setting provides individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation.[24]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[25]

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder

[23] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.
[24] Housing Transition/Navigation is a separate in-lieu service.
[25] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            g. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

            h. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as

described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant

barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems

- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health

conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. [26]

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[26] For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home

- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plan must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility, and emergency department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite services are provided to the participant in his or her own home or another location being used as the home.

The Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children

- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; [27]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; [28]
5. Managing personal financial affairs;

[27] Refer to the Housing Transition/Navigation Services In Lieu of Services
[28] Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and outpatient hospital services, skilled nursing facility, emergency department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADLs.). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.[29]
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

[29] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:
    1. Has resided 60+ days in a nursing facility;
    2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
    3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
    1. Interested in remaining in the community;
    2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
    3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals are directly responsible for paying their own living expenses.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies

- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the participant's housing needs and presenting options.[30]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[31]
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations. [32]

Eligibility (Population Subset)

[30] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.
[31] Refer to Home Modification In Lieu of Services for additional details.
[32] Refer to Housing Deposits In Lieu of Services for additional details.

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00. The only exception to the $5,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or

- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document an order from the participant's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary.

For environmental accessibility adaptations, the managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

   A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

   B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

   C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

4. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $5,000. The only exceptions to the $5,000 total maximum are if the beneficiary's place of residence changes or if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services and emergency transport services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate

and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Up to three medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu

of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transportation services.

Asthma Remediation[33]

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

When authorizing asthma remediation as an in lieu of service, the managed care plan must receive and document:

1. The participant's current licensed health care provider's order specifying the requested remediation(s);
2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;
3. That a home visit has been conducted to determine the suitability of any requested remediation(s).

[33] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and ILOS should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

Asthma remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Asthma remediations are payable up to a total lifetime maximum of $5,000. The only exception to the $5,000 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the beneficiary, or are necessary to enable the

beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

- Before commencement of a physical adaptation to the home or installation of equipment in the home, the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- American Lung Association
- Allergy and Asthma Network
- National Environmental Education Foundation
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

Glossary

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term

Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the

2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

In lieu of services: Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and an enrollee cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided

to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December 31, 2020, with approval pending to extend through calendar year 2021.

AMENDMENT # TO
PROFESSIONAL SERVICES CONTRACT

THIS AMENDMENT # TO THE PROFESSIONAL SERVICES CONTRACT ("Amendment #") shall become effective on January 1, 2023 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____ ("Professional"), with respect to the following facts:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract, by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Professional desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Recital E shall be added to the Contract as follows and subsequent Recitals will be renumbered:

"E. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), (CMS Contract") to operate a Medicare Advantage ("MA") plan and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program". CalOptima may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and DHCS.

2. Article 1, Section 1.2, "Addendums" shall be deleted in its entirety and replaced with the following:

"1.2 Addendums

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements
1.2.1.2 Addendum 2: PACE Program Requirements
1.2.1.3 Addendum 3: Medicare Advantage Program Requirements
1.2.1.4 Addendum 4: Certification Regarding Lobbying"

3. Article 2, Section 2.14 "CalOptima Programs(s)" shall be deleted and replaced with the following:

"2.14 "CalOptima Programs(s)" means the Medi-Cal, PACE, and Medicare Advantage Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A."

4. Article 3, Section 3.1.4 shall be deleted and replaced with the following:

"3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least

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forty five (45) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima."

5. Attachment A, Section 1.1 shall be deleted and replaced with the following:

"1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

_____ Medi-Cal Program (CalOptima Community Network and CalOptima Direct-Administrative)

_____ PACE Program

_____ Medicare Advantage Program (CalOptima Community Network)"

6. Attachment B, "Compensation" shall be deleted in its entirety and replaced with "Attachment B-Amendment {# } - Compensation".

7. Addendum 3, "Cal MediConnect Program Requirements" shall be deleted in its entirety and replaced with Addendum 3, "Medicare Advantage Program Requirements" attached herewith.

8. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Interim Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT B – Amendment I

COMPENSATION

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. MEDI-CAL PROGRAM

A. Primary Care Services

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

    1.1. **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **primary care**, as defined in CalOptima Policies.

    1.2. **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **non professional services**, as defined in CalOptima Policies.

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 Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

    2.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medi-Cal billing and payment guidelines.

    2.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

    2.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

    2.4. 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 Professional for additional justification and these will be handled on a case-by-case basis.

3. Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to PCP yearly or quarterly based on PCP's quality performance and achievement of specified program goals which are determined by CalOptima. The amount of supplemental compensation may be a certain percentage of Community Network's annual fee-for-service payments made to the PCP. CalOptima shall not pay PCP any supplemental payments if this Contract is terminated.

B. Specialist Services

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For Covered Services provided to referred Community Network Members in accordance with CalOptima referral Policies, and as to COD Administrative Members as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

   1.1. **Specialist Professional** services shall be paid at **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for, as defined in the CalOptima Policies.

   1.2. **Non Professional** services shall be paid at **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

   1.3. For **Professional services** provided by a qualifying **CCS paneled Specialist Professional** to a Community Network or COD-Administrative Member less than 21 years of age, CalOptima shall pay Professional **XX%** of the **Current Medi-Cal Fee Schedule**, as defined in CalOptima Policy, for services for which CalOptima is financially responsible. **Non Professional** services shall be paid at **XX%** of the **Current Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

   1.4. For Specialist Physician Services provided to an **Adult Expansion Member** in accordance with CalOptima Policies, and as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or

CPT Code Range	Type of Service	Fee Schedule
10000-69999	**Surgical Range**	**XX% of Medi-Cal**
70000-79999	**Radiology and Radiation Therapy Professional and Technical Components**	**XX% of Medi-Cal**
80000-89999	**Lab and Pathology**	**XX% of Medi-Cal**
90000-99999	**Professional Services**	**XX% of Medi-Cal**
HCPC Codes		**XX% of Medi-Cal**

   1.4.1. Rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will adjust payments made to Professional.

2. Professional shall not be paid for services provided to **Community Network Members** if Member is not referred by a Participating PCP to Professional in accordance with CalOptima referral Policies, except with regard to Emergency Services and CHDP Services, as provided in this Contract. This shall be effective upon the implementation of the Community Network program. Professional will be advised by CalOptima on the implementation date of the Community Network program.

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   3.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medi-Cal billing and payment guidelines.

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3.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

3.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.4. 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 Professional for additional justification and these will be handled on a case-by-case basis.

II. PACE PROGRAM

1. For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or **{xxxxx}** percent **(XX%)** of the Current CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medicare billing and payment guidelines.

   4.2 Professional shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 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 Professional for additional justification and these will be handled on a case-by-case basis.

5. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

III. MEDICARE ADVANTAGE

1. For Covered Services provided to Medicare Advantage Member, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or **{xxxxx}** percent **(XX%)** of the Current CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

2. Prior authorization rules apply for payment of services.

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3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such services will be paid in accordance to Medicare billing and payment guidelines .

   4.2 Professional shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance with the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

   4.5 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 Professional for additional justification and these will be handled on a case-by-case basis.

IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service. In addition, for PCP services, Professional must verify that CalOptima has not assigned Member receiving Covered Services from Professional to a Provider other than Professional prior to providing such services.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable

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Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

8. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   8.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   8.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii). Professional will:

      1) accept the plan payment as payment in full, or

      2) bill the appropriate State source.

   8.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

   8.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

   8.5 Upon receiving notice of Professional invoicing or balance billing a Member for the

difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included by Professional in all of Professional's Subcontracts.

ADDENDUM 3
MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Professional and it Subcontractors agree to retain books, records, contracts, computer or other electronic systems information, medical records, and documents related to this Contract and/or CMS Contract for at least ten (10) years from the final date of the CMS Contract period, or the date of completion of any audit, whichever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Professional and its Subcontractors agree:

   2.1 To maintain and make available contracts, books, computer or other electronic systems, medical records, documents, and records related to this Contract and/or CMS Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory agency or accrediting organizations or their designees to inspect, evaluate, collect, and audit for ten (10) years from the final date of the CMS Contract period or from the date of completion of any audit, whichever is later.

   2.2 For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to in Section 2.1 of this Addendum 5, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Professional's provision of health care services to Members, the cost of such services, and payments received by Professional from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

   2.3 For records subject to review under Section 2.1 of this Addendum 5 by HHS, the Comptroller General, or their designees, CMS will, except in exceptional circumstances, provide notification to CalOptima that a direct request for information has been initiated.

3. Accountability Acknowledgement. Professional further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Professional pursuant to the Contract relative to the OneCare Program are consistent and comply with CalOptima's contractual obligations under the CMS Contract and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Professional under this Contract, Professional warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Professional agrees to perform the delegated activities in a manner consistent with the delegation criteria. Professional agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Professional

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acknowledges that delegation to another entity does not alter Professional's ultimate obligations and responsibilities set forth in this Contract. Professional acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

(b) Reports on Delegated Activities. Professional agrees to provide CalOptima with periodic reports on delegated activities performed by Professional as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Professional agrees to take those corrective actions identified by CalOptima through the audit review process.

(c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Professional, which will be monitored by CalOptima on an ongoing basis. In the event Professional breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Professional as set forth in this Contract. Moreover, CalOptima shall have the right to require Professional to terminate any Subcontracting Professional for good cause, including but not limited to breach of its obligations to perform any delegated duties.

(d) Review of Credentials. Professional shall ensure that the credentials of medical professionals affiliated with the Professional are reviewed by it. Professional agrees that CalOptima will review and approve Professional's credentialing process on ongoing basis.

4. COB Requirements.

(a) MSP Obligations. Professional agrees to comply with MSP requirements. Professional shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third party liens such charges for which the other payer is responsible. Professional agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Professional will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

(b) Professional Authority to Bill Third Party Payers. Professional may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives from Professional Covered Services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Professional may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Reporting Requirements. Professional shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting

encounter and other data including, without limitation, 42 CFR § 422.516. Professional also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

6. Submission and Prompt Payment of Claims. Professional agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Professional bills a third party payor as primary. Professional agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Professional within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Professional, or, CalOptima will contest or deny Professional's claim within forty-five (45) business days following CalOptima's receipt thereof.

7. In addition to Section 2.26 of this Contract, Professional and its Subcontractors shall ensure that payments are not made to individuals or entities included on the Preclusion List.

8. Additional Subcontractor Requirements. If any Covered Services relative to the OneCare Program under this Contract are to be provided by a Subcontractor on behalf of Professional, Professional shall ensure that such subcontracts are in writing and include the following:

8.1 An agreement to comply with the HHS and the Comptroller General, or their designees' right to directly audit, evaluate, collect, and inspect Subcontractors books, contracts, computer or other electronic systems, including medical records and documentation related to CMS' OneCare contract with CalOptima, for any particular contract period for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

8.2 For records subject to review under Section 8.1 of this Addendum 5, except in exceptional circumstances, CMS will provide notification to CalOptima that a direct request for information has been initiated.

8.3 An agreement to Member financial protections in accordance with Section 4.6 of the Contract, including prohibiting Subcontractors from holding a Member liable for payment of any fees that are the legal obligation of Professional.

8.4 An agreement to provide for continuation of health care benefits for the duration of the contract period for which CMS payments have been made; and for Members who are hospitalized on the date its contract with Professional terminates, or, in the event of Professional's insolvency, through the date of discharge.

8.5 An agreement that CalOptima may only delegate activities or functions to a Subcontractor in a manner consistent with requirements set forth in Section 8.7 of this Addendum 5.

8.6 An agreement to ensure that delegated activities or functions are consistent with CalOptima's OneCare contract requirements set forth by CMS.

8.7 If any of CalOptima's activities or responsibilities under this Contract are delegated to a Subcontractor, the following requirements apply and such subcontract must specify:

8.7.1 the delegated activities and reporting responsibilities.

8.7.2 either a provision for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or CalOptima determine that such parties have not performed satisfactorily.

8.7.3 that performance of the parties is monitored by CalOptima on an ongoing basis.

8.7.4 that the credentials of medical professionals affiliated with Subcontractor will be either reviewed by CalOptima; or the credentialing process will be reviewed and approved by CalOptima, and CalOptima must audit the credentialing process on an ongoing basis.

8.7.5 an agreement to comply with all applicable Medicare laws, regulations and CMS instructions.

8.8 If CalOptima delegates selection of Professionals, contractors, or subcontractors to Professional or Subcontractor, CalOptima retains the right to approve, suspend, or terminate such arrangement

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

20. Ratify the Contract with Illumination Foundation for the Provision of Accompaniment Services for Enhanced Care Management (ECM) Under the California Advancing and Innovating Medi-Cal Program (CalAIM); Authorize an Amendment to this Contract; and Authorize Contracts with Other Qualified Accompaniment Services Providers Using the Ancillary Services Contract for Non-Medical Providers Template

Contact

Yunkyung Kim, Chief Operating Officer 714-246-8408

Recommended Actions

1. Ratify the Ancillary Services Contract for Non-Medical Providers with Illumination Foundation for the provision of accompaniment services for Enhanced Care Management (ECM) to eligible CalOptima Direct (COD) members under the California Advancing and Innovating Medi-Cal program (CalAIM), effective January 1, 2022;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Illumination Foundation Ancillary Services Contract, effective January 1, 2022, to be consistent with the Ancillary Services Contract for Non-Medical Provider template; and
3. Authorize the CEO to contract with qualified accompaniment providers, utilizing the Ancillary Services Contract for Non-Medical Provider template, for the provision of accompaniment services for ECM to eligible COD members.

Background & Discussion

On January 1, 2022, the Department of Health Care Services (DHCS) implemented the 5-year CalAIM program that takes a whole-person care approach to improving health outcomes for Medi-Cal members, by incorporating both clinical and nonclinical services. A key CalAIM initiative is ECM, which creates a single, intensive, and comprehensive benefit that is designed to meet the needs of CalOptima's most vulnerable members. ECM services support care coordination with area hospitals as well as primary, dental, behavioral health, specialist, and long-term services & supports providers, administered through members' health networks.

Members receiving ECM services are entitled to receive accompaniment services for medically necessary appointments. Accompaniment services provide a non-clinical individual to escort the member to and from medically necessary appointments. These include scheduled appointments such as doctors' visits, and unplanned visits such as urgent care visits. Services are proposed to be provided under CalOptima's Ancillary Services Contract for Non-Medical Providers under specific billing codes. Since the billing codes have no established rate for Medi-Cal, the rates are negotiated within community standards for accompaniment services. To expand access, CalOptima will contract with any willing and qualified accompaniment provider.

To ensure that eligible COD members have access to ECM accompaniment services starting January 1, 2022, staff request that the Board ratify CalOptima's Ancillary Services Contract for Non-Medical

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Provider with Illumination Foundation. Staff further requests that the Board authorize an amendment to this contract to make it consistent with the template described below.

Staff has revised the Ancillary Services Contract for Non-Medical Provider template to reflect accompaniment services for ECM as a covered benefit for eligible COD members. As such, staff requests that the Board to authorize the use of the template to contract with additional qualified accompaniment providers on a go forward basis.

Fiscal Impact
Management included projected revenues and expenses associated with the ECM benefit in the CalOptima Fiscal Year 2021-22 Operating Budget using the best available information at the time. As this is a new benefit, utilization by eligible Medi-Cal members is difficult to predict. However, staff anticipates forecasted Medi-Cal revenue for the new benefit will be sufficient to cover the anticipated costs through June 30, 2022.

Rationale for Recommendation
The recommended contract and amendment with Illumination Foundation, as well as utilizing the template to contract for accompaniment services, will ensure access to this covered benefit for eligible CalOptima Direct Medi-Cal members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Ancillary Services Contract for Non-Medical Providers with Illumination Foundation
3. Ancillary Services Contract for Non-Medical Providers Template for Accompaniment Services

Board Actions
N/A

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Illumination Foundation	1091 N. Batavia St	Orange	CA	92867

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ANCILLARY SERVICES CONTRACT
NON-MEDICAL PROVIDER

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **The Illumination Foundation** ("Provider"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

D. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract

1.1 "California Children 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.

1.2 "California Children's Services (CCS) Eligible Condition(s)" means a physically handicapping condition defined in Title 22 CCR Section 41515.2 – 41518.9.

1.3 "CCS Providers" or "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.

1.4 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.5 "CDA" means the California Department of Aging.

1.6 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.6.1 CalOptima Direct Members who are assigned to CalOptima Community Network (CCN) in accordance with CalOptima Policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in CCN.

1.6.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have

a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.7 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.8 "CalOptima Programs" means the Medi-Cal, OneCare, Multipurpose Senior Service Program (MSSP), Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.9 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.10 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.11 "Clean Claim" means a Claim or invoice that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.12 "CalOptima Community Network" or "CCN" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. CCN Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

1.13 "Community Supports" means, as set forth in 42 CFR § 438.3(e)(2),services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and theMember and must be approved by DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptimaPolicy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite).

1.14 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.15 "Covered Services" means those items and services available to Members set forth in Attachment A of this Contract.

1.16 "ECM Care Team" means a team of staff employed or contracted by the CalOptima, serving, as an ECM Provider through CalOptima Direct, that provides ECM services to ECM Members of CalOptima Direct.

1.17 "ECM Member" means a CalOptima Medi-Cal Member who meets inclusion criteria for one of the ECM Populations of Focus, is authorized to receive ECM services and is enrolled in CalOptima Direct.

1.18 "ECM Population of Focus" means the following Members who areeligible to participate in ECM under the CalAIM initiative, as defined by DHCS, and subject to the phase-in requirements prescribed by DHCS and the Member transition requirements for the Health Homes Program (HHP) and Whole Person Care (WPC):

1.18.1 Adult Populations of Focus include the following: (i) Individuals and families experiencing homelessness; (ii) Adult high utilizers; (iii) Adults with serious mental illness and/or substance use disorders; (iv) Individuals transitioning from incarceration; (v) Individuals who are at risk

for institutionalization and are eligible for long- term care; and (vi) Nursing facility residents who want to transition into the community.

1.18.2 Populations of Focus for children and youth include the following: (i) Children (up to age 21) experiencing homelessness; (ii) High utilizers; (iii) Serious emotional disturbance or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; (iv)Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; (v) Involved in, or with a history of involvement in, child welfare (including fostercare up to age 26); and (vi) Transitioning from incarceration.

1.19 "ECM Provider" means CalOptima Direct serving as the provider ofECM to Members enrolled in CalOptima Direct under CalOptima's Medi-Cal Program.

1.20 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.21 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The Encounter Data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

1.22 "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.23 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC, and their respective agents and contractors, including quality improvement organizations (QIOs).

1.24 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.25 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.26 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.27 "Lead Care Manager" means a Member's designated care manager for ECM, who is on staff with CalOptima, serving as an ECM Provider through CalOptima Direct. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible forcoordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

1.28 "Licenses" means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.29 "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).

1.30 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration and who is enrolled in the CalOptima Medi-Cal Program and CalOptima Direct.

1.31 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.32 "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.

1.33 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.34 "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.

1.35 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.36 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

1.37 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 In accordance with Section 2.20 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in

manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.9 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.10 Disclosure of Provider Ownership. Provider shall complete Attachment D and provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.11 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

2.12 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.13 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 Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.14 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through

cultural diversity training, fostering in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials in the threshold languages identified by CalOptima at no higher than the sixth (6th) grade reading level.

2.15 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding arranging for the provision of non-medical services treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.16 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.17 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Provider and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60,

"Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or Provider. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or Provider 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.

2.18 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed, or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.19 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable

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

2.20 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.21 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with the requests from Government Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.22 Subcontracting of Covered Services. Provider shall not subcontract for any Covered Services without the prior approval of CalOptima. Any subcontracting approved by CalOptima is subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

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2.22.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.22.2 An agreement to maintain such books and records: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.22.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.22.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other customers.

2.22.5 An agreement to comply with CalOptima's Compliance Program.

2.22.6 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.23 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.24 Participation Status. Provider shall have policies and procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

2.24.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.24.2 Provider shall immediately disclose to CalOptima, including but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.24.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

2.24.4 Provider shall include the obligations of this Section in its Subcontracts.

2.24.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.25 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be reviewed to confirm that required Licenses and other applicable qualifications are met. to the extent required by CalOptima Policy.

2.26 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for

inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.28 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.29 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.30 Facility Construction or Repair. When applicable for purposes of construction or repair of facilities, Provider shall comply with the provisions in the following acts and/or will include such provisions in any applicable Subcontracts:

- Copeland "Anti-Kickback" Act (18 USC 874, 40 USC 2760) (29 CFR, Part 3)
- Davis-Bacon Act (40 USC 276a-7) (29 CFR, Part 5)
- Contract Work Hours and Safety Standards Act (40 USC 327-330) (29 CFR, Part 5)
- Executive Order 1126 of September 14, 1965 entitled, "Equal Employment Opportunity" as amended by Executive Order 11375 of October 13, 1967, as supplemented in Department of Labor Regulations (41 CFR, Part 60).

When Provider's agreement provides funding for both construction and non-construction activities, Provider shall obtain prior written approval from CalOptima before making any fund or budget transfers between construction and non-construction.

2.31 Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

2.31.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

2.31.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

2.31.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

2.31.1.3 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 Sub provision 13.1.2 herein; and

2.32.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

2.33.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

2.34.1.6 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.

2.31.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

2.31.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

2.31.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

2.32 Lobbying Restrictions and Disclosure Certification. Provider shall complete and submit the lobbying disclosure form required by federal law, when applicable.

2.32.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

2.32.2 Certification and Disclosure Requirements

2.32.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment E, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 2.30.3 of this provision.

2.32.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment E-1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 2.30.3 of this provision if paid for with appropriated funds.

2.32.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 2.30.2.2 herein. An event that materially affects the accuracy of the information reported includes:

2.32.2.3.1 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;

2.32.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

2.32.2.3.3 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.

2.32.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 2.30.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

2.32.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 2.30.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

2.32.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal,

amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2.33 Provider's Agents' Qualifications. Provider shall verify that the qualifications of all Provider's Agents providing Covered Services under this Contract comply with the requirements of this Contract, CalOptima Policies, and DHCS guidance. In addition, for Provider's Agents that enter into Members' homes or have face-to-face contact with Members, Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. Provider shall comply with all applicable laws in conducting background investigations, and shall exclude unqualified Agents from providing services under this Contract.

2.34 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to CalOptima Health Networks the same terms regarding Provider performance, duties and obligations and rates for Ancillary Services provided to CalOptima Members enrolled in Health Networks as are set forth in this Contract, and to extend to the County of Orange the same terms regarding Provider performance, duties and obligations, and rates for Ancillary Services as are set forth in this Contract.

2.35 Whole Child Model Program Compliance. If Provider is a CCS authorized provider, then in the provision of CCS Services to CalOptima Members, the 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.

2.36 CCS Provider Compliance.

2.36.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.36.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.36.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.36.2.2 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.

2.37 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.38 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.39 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from

CalOptima for such Covered Services. Upon submission of a Clean Claim or invoice, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C.

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies Procedures as may be amended from time to time.

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 or invoices for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.5.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.5.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract.

4.5.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.5.4 Upon receiving notice of Provider invoicing or balance billing a Member for Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.5.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.6 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider

acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

4.6.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.6.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Insurance Requirements

5.2.1 Professional Liability:

If providing Professional Services under this contract, the Provider at its sole cost and expense, shall maintain a Professional Liability Insurance policy covering itself and any Subcontractors with minimum limits as follows:

Professional Liability providing Covered Services: $1,000,000 per incident/$2,000,000 aggregate

5.2.2 Commercial General Liability/Commercial Automobile Liability:

Provider, at its sole cost and expense shall maintain a Commercial General Liability and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability: $1,000,000 per occurrence/$2,000,000 aggregate

(Including Personal Injury)

Commercial Automobile Liability: * $1,000,000 Combined Single Limit

Additional insured wording is required on both policies as well as primary and non-contributory wording and Waiver of Subrogation. Additional Insured wording to include: Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

*(Charter-party carriers of passengers:)

If applicable, Provider shall comply with the Public Utilities Commission (PUC) General Order No. 115-G, which requires higher levels of insurance for charter-party carriers of passengers and is based on seating capacity as follows:

$1,500,000 if seating capacity is 8-15

$5,000,000 if seating capacity is over 15 unless otherwise amended by future regulations.

In the case of a charter-party carrier with seating capacity of 7 or less, CalOptima will require $1,000,000 Combined Single Limit.

5.2.3 Workers' Compensation:

Provider, at its sole cost and expense shall maintain a Workers' Compensation Insurance policy as required by the State of California with minimum limits as follows:

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Employers' Liability Insurance:

$1,000,000 Bodily injury each accident

$1,000,000 Bodily injury policy limit

$1,000,000 Bodily injury each employee

Waiver of Subrogation wording is required and to include:

Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

5.2.4 Commercial Crime:

If applicable, Provider, at its sole cost and expense shall maintain a commercial crime policy covering theft and dishonesty, forgery and alterations, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property as follows:

Commercial Crime Insurance: $1,000,000 per occurrence

5.2.5 Cyber and Privacy Liability Insurance:

If applicable, Provider shall maintain the following minimum coverages for such length of time as necessary to cover any and all claims:

Cyber and Privacy Liability Insurance: $1,000,000 each coverage (including Privacy and Network Liability;

Internet Media Liability;

Business Interruption and Expense;

Data Extortion;

Regulatory Proceeding; and Data Breach Notification & Credit Monitoring)

5.2.6 Bonding:

If providing services which require bonding, Provider shall be bonded at amounts usual or customary in Provider's industry and type of service.

5.3 Insurer Ratings.

Such insurance shall be provided by an insurer:

(a) Rated by A.M. Best with rating of A- VII or better; and

(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.4 Captive Risk Retention Group/Self Insured:

Where any of the insurances mentioned by Section 5.2 above are provided by a Captive Risk Retention Group or self-insured, Section 5.3 above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

5.5 Cancellation or Material Change:

The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract. Thirty (30) days prior written notice be given to CalOptima in the event of cancellation.

5.6 Certificates of Insurance:

Certificates of Insurance of the above insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

5.7 Subcontractors:

Provider shall require each of its Subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

5.8 Failure or refusal to maintain or produce proof of Insurance:

If Provider fails or refuses to maintain or produce proof of the insurance required by Section 5.2, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect Provider's right to be paid for its time and materials expended prior to notification of termination. Provider waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of Insurance by CalOptima.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, CDA or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, CDA or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.3 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.4. Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.4.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.4.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.4.3 Declaration of Confidentiality. If Provider and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Provider and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.5 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through **June 30, 2022**. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, permits and certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90)

days prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits, as well as Provider's response to the CalOptima's Request for Proposal (RFP), if applicable, and any further information or clarification submitted as part of the RFP process, and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder. In the event of any inconsistency between the RFP and this Contract, the terms and provisions of this Contract shall govern and control.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

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

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Provider hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:

Pooja Bhalla
Name

Executive Director of Healthcare Services
Title

1091 North Batavia Street Orange, CA 92867
Address

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said

party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

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

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective on January 1, 2022 (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Provider	**CalOptima**
[redacted]	[redacted]
Signature	Signature
Pooja Bhalla	
Print Name	Print Name
Executive Director of Healthcare Services	Chief Operating Officer
Title	Title
12/23/21	Dec 23, 2021
Date	Date

ATTACHMENT A

CONTRACTED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Medi-Cal Program. Provider shall furnish Covered Services to eligible CalOptima Direct Members enrolled in the CalOptima Medi-Cal Program.

ARTICLE 2
SERVICES

2.1 Scope of Work. "Covered Services" as referred to in this Contract means accompaniment services for Enhanced Care Management (ECM) as described below:

2.1.1 Accompaniment Services.

2.1.1.1 Provider shall provide accompaniment services to ECM Members for medically necessary appointments in a timely manner as approved and requested by CalOptima, as follows:

2.1.1.1.1 Outreach to an ECM Member in advance of a scheduled appointment to coordinate the provision of accompaniment services, including to confirm the appointment date and time, and to provide information on accompaniment process, what to expect at the appointment, and identification of potential questions.

2.1.1.1.2 On a case-by-case basis, as requested by CalOptima, discuss any special instruction with an ECM Member in advance of an appointment.

2.1.1.1.3 Contact an ECM Member the business day prior to the appointment as a reminder and for confirmation of the appointment.

2.1.1.1.4 Provide same-day services to an ECM Member who needs accompaniment to an unplanned service, such as urgent care and pharmacy.

2.1.1.1.5 Meet an ECM Member at a clinical provider office and attend an appointment with the ECM Member at clinical provider office as requested by CalOptima and provide an update regarding appointment visit to CalOptima.

2.1.1.2 Provider understands that ECM Members are expected to arrange their own transportation or request CalOptima to provide non-medical transportation to the appointment. Provider may accompany an ECM Member in the vehicle that is driven by CalOptima's non-medical transportation vendor by meeting member at their preferred location. Provider shall not drive Member to the appointment or allow an ECM Member to drive the Provider to the appointment.

2.1.1.3 CalOptima will identify ECM Member for accompaniment services for a specific appointment and notify Provider.

2.1.1.4 Provider shall provide accompaniment(s) as set forth in this Attachment within Orange County. Provider agrees to provide accompaniment(s) outside of Orange County as requested by CalOptima.

2.1.1.5 On a case-by-case basis, CalOptima may request to support the ECM Member and provide accompaniment beyond business hours including hours falling during weekends.

2.1.1.6 If requested by CalOptima and with ECM Member's consent, Provider shall send to CalOptima, no later than two (2) business days following the date of the appointment, a summary report of the discussion, questions raised, next appointment (if any), next steps

for the ECM Member, and any referrals for follow-up by CalOptima. CalOptima will provide a standard form that Provider will be required to complete.

2.1.1.7 Provider shall participate in ECM Care Team meetings and in implementing the ECM Member's care management plan, as requested by CalOptima. CalOptima will notify Provider and conduct ECM Care Team meetings outside of the ECM Member appointments.

Remainder of this page intentionally left blank

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICE

1. CALOPTIMA DIRECT MEMBERS

1.1 Cal Optima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;
b. Name and phone number of the care taker, if applicable;
c. Language or sign language needed;
d. Date and time of the appointment;
e. Address and telephone number of the facility where the appointment is to take place;
f. Estimated amount of time the interpretation service will be needed; and
g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request, and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

The Illumination Foundation_Medi-Cal_Accompaniment_C11342772AA
Back to Agenda

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima the following amounts:

I. Medi-Cal Program Reimbursement

Accompaniment Services Compensation

For Medi-Cal Members, CalOptima shall reimburse for Covered Services as follows:

HCPCS Code	Modifier	Type of Service	Unit of Service (uos)	UnitRate
G9012	U2	In-Person: Provided by Non-Clinical Staff	15 Minutes equals 1 UOS; Multiple UOS allowed	[redacted]
G9012	U2, GQ	Phone/Telehealth: Provided by Non-Clinical Staff.	15 Minutes equals 1 UOS; Multiple UOS allowed	[redacted]

- For In-Person services (HCPCS G9012/Modifier U2), Provider's start time begins when face-to-face is initiated with Member and shall end once face-to-face time with member concludes.
- Provider shall utilize current billing codes and modifiers for Med-Cal Accompaniment Services.
- Unless specified otherwise in this contract, Medi-Cal billing rules and payment policies and guidelines for billing and payment will apply.
- Services not contained in the above fee schedule are not reimbursable.
- Claims shall be billed on a CMS 1500 claim form or billed electronically (EDI).

ATTACHMENT D

DISCLOSURE FORM

The Illumination Foundation
Name of Provider

The undersigned hereby certifies that the following information regarding **The Illumination Foundation** (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

N/A

Co-Owner(s):

N/A

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

N/A

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

N/A

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

N/A

Dated: 12/23/21

Signature [redacted]

Name: Pooja Bhalla
(Please type or print)

Title: Executive Director of Healthcare Services
(Please type or print)

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.

Illumination Foundation	Pooja Bhalla
Name of Contractor	Printed Name of Person Signing for Contractor
	[redacted]
Contract / Grant Number	Signature of Person Signing for Contractor
12/23/21	Executive Director of Healthcare Services
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:
contract grant cooperative agreement loan loan guarantee loan insurance	bid/offer/application initial award post-award	initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
Congressional District, If known:	Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned	13. Type of Payment (Check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:
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)

Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC

ADDENDUM 1

MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to CalOptima Direct Members under the CalOptima Medi-Cal Program. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. Provider shall maintain and retain all records of all items and services provided Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract for provision of services to CalOptima Medi-Cal Members due to fraud.

3. Form of Records. Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation

liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation.

5.1 Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or Subcontracts entered into under this Contract. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its subcontractor's possession, in accordance with the DHCS Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

5.2 In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2 If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.3 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. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

6. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

8. Medi-Cal Credentialing. If Provider is of a provider type that is not able to enroll in Medi-Cal through DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal

Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

9. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

10. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

    Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

    10.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

    10.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

    10.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

    10.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

11. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

    11.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

        11.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

        11.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement,

theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

11.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 12.1.2 herein; and

11.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

11.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

11.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

11.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

11.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

11.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

12. DHCS Directions. If required by DHCS, Provider shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Lobbying Restrictions and Disclosure Certification.

13.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

13.2 Certification and Disclosure Requirements

13.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 13.3 of this provision.

13.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 13.3 of this provision if paid for with appropriated funds.

13.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 13.2.2 herein. An event that materially affects the accuracy of the information reported includes:

13.2.3.1 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;

13.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

13.2.3.3 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.

13.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 13.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

13.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 13.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

13.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. Additional Subcontracting Requirements.

14.1 Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

14.1.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

14.1.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later.

14.2 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

14.2.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

14.2.2 Subcontract or its amendments are subject to DHCS approval as provided in the DHCS Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract.

14.2.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 20 of this Addendum 1.

14.2.4 An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.21 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Addendum 1.

14.2.5 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 15 of this Addendum 1.

14.2.6 An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 14.1 of this Addendum 1.

14.2.7 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 15 of this Addendum 1.

14.2.8 An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the DHCS Contract or the Contract for any reason, in accordance with Section 18 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

14.2.9 An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.5 of the Contract.

14.2.10 An agreement to notify DHCS in the manner provided in Section 7.8 of the Contract in the event the Subcontract is amended or terminated.

14.2.11 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.15 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.14 or the Contract.

14.2.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract.

14.2.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.11 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

14.2.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 24 of this Addendum 1 and Section 6.4.3 of the Contract.

14.2.15 An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.5 of the Contract.

14.2.16 An agreement for the establishment and maintenance of and access to administrative records as set forth in Section 6.2 of the Contract and Sections 1 and 3 of this Addendum 1.

14.2.17 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

14.2.18 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.4.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

15. State's Right to Monitor. Provider shall comply with all monitoring provisions of this Contract and the DHCS Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS. Without limiting the foregoing, CalOptima and authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. The monitoring activities will be either announced or announced. Staff designated by authorized State agencies will have access to all security areas and the Provider

will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

16. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

17. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

18. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's DHCS Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor DHCS Contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

19. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

20. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Provider or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

21. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation Provision".

22. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

23. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

24. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

Addendum 2

DHCS Requirements for Enhanced Care Management

The following additional terms and conditions apply to ECM-related Covered Services under this Contract that are furnished to CalOptima Direct Members enrolled in the CalOptima Medi-Cal Program. Provider is subject to the requirements below.

1. Provider Experience and Qualifications

1.1 Provider shall be experienced in serving the ECM Population(s) of Focus it will serve and shall have experience and expertise with the Covered Services it will provide under this Contract.

1.2 Provider shall comply with all applicable State and federal laws and regulations and all ECM program requirements in the DHCS CalOptima ECM and Community Supports Contract and associated guidance.

1.3 Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities set forth in Attachment A of this Contract including accompanying Members to critical appointments when necessary. Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

1.4 To the extent applicable to the provision of Covered Services under this Contract, Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each ECM Member.

1.5 To the extent applicable to the provision of Covered Services under this Contract, Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of an ECM Member care plan that can be shared with other Providers and organizations involved in each ECM Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

2. Medi-Cal Enrollment/CalOptima's Vetting Process

2.1 If a State-level enrollment pathway exists, Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS APLs including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment

2.2 If APL 19-004 does not apply to the Provider, the Provider shall comply with CalOptima's process for vetting the Provider, which may extend to individuals employed by or delivering Covered Services under this Contract on behalf of the Provider, to ensure the Provider can meet the capabilities and standards required for the provision of Covered Services under this Contract.

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3. Identifying Members for ECM. Provider is encouraged to identify Members who would benefit from ECM and send a request to CalOptima, to determine if the Member is eligible for ECM, consistent with CalOptima's process for such request.

4. Lead Care Manager. Provider understands that upon initiation of ECM, CalOptima shall ensure each assigned ECM Member has a Lead Care Manager who interacts directly with the ECM Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), specialty mental health services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health (SDOH) needs, regardless of setting.

4.1 To the extent applicable to the provision of Covered Services under this Contract, Provider agrees to fully cooperate and coordinate with an ECM Member's assigned Lead Care Manager.

5. Process for Changing ECM Providers

5.1 Provider understands that CalOptima shall: (i) Advise the ECM Member on the process for changing ECM providers, which is permitted at any time; (ii) Advise the ECM Member on the process for switching ECM providers, if requested; and (iii) Implement any requested ECM provider change within thirty (30) calendar days.

5.2 Provider agrees to notify CalOptima if the Provider is informed that the ECM Member wishes to change ECM providers.

6. Provider Staffing. At all times, Provider shall have adequate staff to ensure its ability to carry out responsibilities for the provision of Covered Services to each assigned ECM Member consistent with this Contract, CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS-CalOptima ECM Community Supports Contract and any other related DHCS guidance.

7. Outreach and Member Engagement into ECM. Provider understands that CalOptima shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach. CalOptima shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

7.1 Provider understands that CalOptima shall conduct outreach primarily through in- person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. CalOptima may supplement in-person visits with secure teleconferencing and telehealth, where appropriate, with the Member's consent, and in compliance with CalOptima Policies. CalOptima shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (i) mail; (ii) email; (iii) texts; (iv) telephone calls; and (v) telehealth.

8. Non-Discrimination. Provider shall comply with non-discrimination requirements set forth in State and federal law and this Contract.

9. Initiating Delivery of ECM

9.1 Provider understands that CalOptima shall obtain, document, and manage Member authorization for the sharing of personally identifiable information between CalOptima and the Provider, Community Supports Providers, and other providers involved in the provision of Member care to the extent required by federal law.

9.2 Provider understands that Member authorization for ECM-related data sharing is not required for CalOptima to initiate delivery of ECM unless such authorization is required by federal law.

9.3 When federal law requires authorization for data sharing, CalOptima shall communicate that it has obtained Member authorization for such data sharing to the Provider, and Provider agrees to comply with such Member authorization.

10. Discontinuance of ECM

10.1 Provider understands that CalOptima shall discontinue ECM under the following circumstances: (i) The Member has met their care plan goals for ECM; (ii) The Member is ready to transition to a lower level of care; (iii) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) CalOptima has not had any contact with the Member despite multiple attempts.

10.2 Provider understands that when ECM is discontinued, or will be discontinued for the Member, CalOptima is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. CalOptima shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).

11. ECM Requirements and Core Service Components of ECM

11.1 Provider understands that CalOptima shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in CalOptima Direct. CalOptima shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

11.1.1 To the extent applicable to the provision of Covered Services under this Contract, Provider agrees to fully cooperate and coordinate with CalOptima to ensure the approach is person- centered, goal oriented, and culturally appropriate.

11.2 Subject to all applicable requirements set forth in this Contract (including, but not limited to, subcontracting requirements and the prior written approval of CalOptima), if the Provider subcontracts with other entities to administer ECM functions, the Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth in this Addendum and CalOptima Policies and that its Subcontractors comply with all requirements in the DHCS ECM Provider Standardized Terms and Conditions and the DHCS-CalOptima ECM and Community Supports Contract. Notwithstanding any subcontracting arrangements, the Provider shall remain responsible and accountable for any subcontracted ECM functions related to the provision of Covered Services under this Contract.

11.3 Provider understands that CalOptima shall: (i) Ensure each Member receiving ECM has a Lead Care Manager; (ii) Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources; and (iii) Ensure non- duplication of

services in the event that a Member is receiving care management or duplication of services from multiple sources.

11.3.1 To the extent applicable to the provision of Covered Services under this Contract, Provider agrees to follow CalOptima's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

11.4 To the extent applicable to the provision of Covered Services under this Contract, Provider shall collaborate with area hospitals, primary care providers, behavioral health providers, specialists, dental providers, providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care for ECM.

11.5 With the exception of Section 11.5.1 of this Addendum, Provider understands that CalOptima shall provide the following core service components of ECM to each assigned Member, in compliance with CalOptima Policies GG.1354: Enhanced Care Management – Eligibility and Outreach and GG.1353: Enhanced Care Management Service Delivery: (i) Outreach and engagement of Members into ECM; (ii) Comprehensive assessment and care management plan; (iii) Enhanced coordination of care; (iv) Health promotion; (v) Comprehensive transitional care; (vi) Member and family supports; and (vii) Coordination of and referral to community and social support services.

11.5.1 Provider shall provide Covered Services under this Contract in compliance with applicable CalOptima Policies, including CalOptima Policy GG.1353: Enhanced Care Management Service Delivery, to each ECM Member assigned by CalOptima to Provider.

12. Training. Provider shall participate in all mandatory, provider-focused ECM training and technical assistance provided by CalOptima, including in-person sessions, webinars, and/or calls, as necessary. Provider shall ensure that its staff who will be providing Covered Services under this Contract complete the training required by CalOptima and DHCS prior to participating in the provision of such Covered Services.

13. Data Sharing to Support ECM

13.1 If and to the extent necessary to support the Provider's provision of Covered Services under this Contract, CalOptima agrees to provide to the Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

13.1.1 Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned by CalOptima to the Provider for the provision of Covered Services under this Contract;

13.1.2 Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members, as available; and

13.1.3 Reports of performance on quality measures and/or metrics, as requested.

13.2 Provider acknowledges and agrees that encounter and/or claims data are not necessary for the provision of Covered Services under this Contract, and as such will not be provided by CalOptima to the Provider.

14. Claims Submission and Reporting. Provider shall submit claims to CalOptima for the provision of Covered Services under this Contract using the national standard specifications and code sets to be defined by DHCS. In the event Provider is unable to submit claims to CalOptima for Covered Services using the national standard specifications and DHCS-defined code sets, the Provider shall submit an invoice to CalOptima with a minimum set of data elements (to be defined by DHCS) necessary for CalOptima to convert the invoice to an encounter for submission to DHCS.

15. Quality and Oversight. Provider acknowledges that CalOptima will conduct oversight of Provider's participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. Provider shall respond to all requests from CalOptima for information and documentation to permit ongoing monitoring of ECM.

16. Payment for Covered Services

16.1 Provider understands that CalOptima shall pay the Provider for the provision of Covered Services in accordance with this Contract. Provider is eligible to receive payment when ECM is initiated for CalOptima Direct Member for whom the Provider has furnished Covered Services in accordance with this Contract.

16.2 Provider understands that CalOptima shall pay 90 percent of all Clean Claims from Provider within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all Clean Claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

ANCILLARY SERVICES CONTRACT
NON-MEDICAL PROVIDER

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **@@Provider@@** ("Provider"), with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. Provider is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

D. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to CalOptima Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments and Schedules attached hereto, apply to the terms set forth in this Contract

1.1 "California Children 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.

1.2 "California Children's Services (CCS) Eligible Condition(s)" means a physically handicapping condition defined in Title 22 CCR Section 41515.2 – 41518.9.

1.3 "CCS Providers" or "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.

1.4 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.5 "CDA" means the California Department of Aging.

1.6 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

1.6.1 CalOptima Direct Members who are assigned to CalOptima Community Network (CCN) in accordance with CalOptima Policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in CCN.

1.6.2 "CalOptima Direct-Administrative" or "COD-Administrative" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have

a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any registered Practitioner for Physician services.

1.7 "CalOptima Policies" means CalOptima policies and procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

1.8 "CalOptima Programs" means the Medi-Cal, OneCare, Multipurpose Senior Service Program (MSSP), Program of All-Inclusive Care for the Elderly (PACE) and Cal MediConnect (OneCare Connect) programs administered by CalOptima. Provider participates in the specific CalOptima Program(s) identified on Attachment A.

1.9 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Inspector General, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care, the Comptroller General and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

1.10 "Claim" means a request for payment submitted by Provider in accordance with this Contract and CalOptima Policies.

1.11 "Clean Claim" means a Claim or invoice that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as defined in the CalOptima Program(s).

1.12 "CalOptima Community Network" or "CCN" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. CCN Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

1.13 "Community Supports" means, as set forth in 42 CFR § 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member and must be approved by DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite).

1.14 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.15 "Covered Services" means those items and services available to Members set forth in Attachment A of this Contract.

1.16 "ECM Care Team" means a team of staff employed or contracted by the CalOptima, serving, as an ECM Provider through CalOptima Direct, that provides ECM services to ECM Members of CalOptima Direct.

1.17 "ECM Member" means a CalOptima Medi-Cal Member who meets inclusion criteria for one of the ECM Populations of Focus, is authorized to receive ECM services, and is enrolled in CalOptima Direct.

1.18 "ECM Population of Focus" means the following Members who are eligible to participate in ECM under the CalAIM initiative, as defined by DHCS, and subject to the phase-in requirements prescribed by DHCS and the Member transition requirements for the Health Homes Program (HHP) and Whole Person Care (WPC):

1.18.1 Adult Populations of Focus include the following: (i) Individuals and families experiencing homelessness; (ii) Adult high utilizers; (iii) Adults with serious mental illness and/or substance use disorders; (iv) Individuals transitioning from incarceration; (v) Individuals who are at risk

for institutionalization and are eligible for long- term care; and (vi) Nursing facility residents who want to transition into the community.

1.18.2 Populations of Focus for children and youth include the following: (i) Children (up to age 21) experiencing homelessness; (ii) High utilizers; (iii) Serious emotional disturbance or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; (iv) Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; (v) Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and (vi) Transitioning from incarceration.

1.19 "ECM Provider" means CalOptima Direct serving as the provider of ECM to Members enrolled in CalOptima Direct under CalOptima's Medi-Cal Program.

1.20 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

1.21 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The Encounter Data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

1.22 "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.23 "Government Agencies" means Federal and State agencies that are parties to the Government Contracts including, HHS/CMS, DHCS, DMHC, and their respective agents and contractors, including quality improvement organizations (QIOs).

1.24 "Government Contract(s)" means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

1.25 "Government Guidance" means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Program(s).

1.26 "Health Network" means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to non-COD Members on a capitated basis.

1.27 "Lead Care Manager" means a Member's designated care manager for ECM, who is on staff with CalOptima, serving as an ECM Provider through CalOptima Direct. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

1.28 "Licenses" means all licenses and permits that Provider is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

1.29 "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).

1.30 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration and who is enrolled in the CalOptima Medi-Cal Program and CalOptima Direct.

1.31 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

1.32 "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.

1.33 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies.

1.34 "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.

1.35 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

1.36 "Subcontractor" means a person or entity who has entered into a Subcontract with Provider for the purposes of filling Provider's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

1.37 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

2.1.1 Provider shall furnish Covered Services identified in Attachment A to eligible Members in the applicable CalOptima Programs. Provider shall furnish such items and services in a manner satisfactory to CalOptima.

2.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Provider's obligation to provide Covered Services hereunder.

2.1.3 In accordance with Section 2.20 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

2.2 Licensure. Provider represents and warrants that it has, and shall maintain during the term of this Contract, valid and active Licenses applicable to the Covered Services and for the State in which the Covered Services are rendered.

2.3 Regulatory Approvals. Provider represents and warrants that it has, and shall maintain during the term of this Contract, applicable Medi-Cal and Medicare provider and/or supplier numbers.

2.4 Good Standing. Provider represents it is in good standing with State licensing boards applicable to its business, DHCS, CMS and the DHHS Officer of Inspector General ("OIG"). Provider agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

2.5 Geographic Coverage Area. Provider shall serve Members in all areas of Orange County, California.

2.6 Eligibility Verification. Provider shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Provider shall collect SOC in accordance with CalOptima Policies.

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in

manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

2.9 Marketing Requirements. Provider shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

2.10 Disclosure of Provider Ownership. Provider shall complete Attachment D and provide CalOptima with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than five percent (5%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under the CalOptima Programs as requested by CalOptima. Provider shall notify CalOptima immediately of any changes to the information included by Provider in the disclosure forms submitted to CalOptima.

2.11 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate and cooperate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

2.12 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Covered Services as described in this Contract.

2.13 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 Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.14 Linguistic and Cultural Sensitivity Services. Provider shall comply with CalOptima Policies including, without limitation, the requirements set forth herein related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, such as, but not limited to, Vietnamese and Hispanic persons. Provider shall in its policies, administration, and services practice the values of (i) honoring the Members' beliefs, traditions and customs; (ii) recognizing individual differences within a culture; (iii) creating an open, supportive and responsive organization in which differences are valued, respected and managed; and (iv) through

cultural diversity training, fostering in staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials in the threshold languages identified by CalOptima at no higher than the sixth (6th) grade reading level.

2.15 Provision of Interpreters. Provider shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding arranging for the provision of non-medical services treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, CalOptima Policies and Attachment B to this Contract.

Interpreters shall be used where needed and when technical or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

2.16 CalOptima's Compliance Program and Other Guidance. Provider and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Provider's Agents") shall comply with the requirements of CalOptima's Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.17 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Provider and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Provider and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Provider and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Provider and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60,

"Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Provider and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or Provider. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Provider and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or Provider 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.

2.18 Compliance with Applicable Laws. Provider shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed, or which may come into effect during the term of the Contract, which in any manner affects the Provider's performance under this Contract. Provider understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Provider and any Subcontractor are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Provider agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require any Subcontractor to comply accordingly. Provider agrees to include the requirements of this section in its contracts with any Subcontractor.

2.19 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable

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

2.20 No Discrimination (Member). Neither Provider nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, heath status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.21 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with the requests from Government Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.22 Subcontracting of Covered Services. Provider shall not subcontract for any Covered Services without the prior approval of CalOptima. Any subcontracting approved by CalOptima is subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

2.22.1 An agreement to make all books and records relative to the provision of and reimbursement for Covered Services furnished by Subcontractor to Provider available at all reasonable times for inspection, examination or copying by CalOptima or duly authorized representatives of the Government Agencies in accordance with Government Contract requirements.

2.22.2 An agreement to maintain such books and records: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

2.22.3 An agreement for the establishment and maintenance of and access to records as set forth in this Contract.

2.22.4 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other customers.

2.22.5 An agreement to comply with CalOptima's Compliance Program.

2.22.6 An agreement to comply with Member financial and hold harmless protections as set forth in this Contract.

2.23 Fraud and Abuse Reporting. Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) working days of the date when Provider first becomes aware of or is on notice of such activity.

2.24 Participation Status. Provider shall have policies and procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

2.24.1 Provider and Provider's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

2.24.2 Provider shall immediately disclose to CalOptima, including but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.24.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

2.24.4 Provider shall include the obligations of this Section in its Subcontracts.

2.24.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.25 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be reviewed to confirm that required Licenses and other applicable qualifications are met. to the extent required by CalOptima Policy.

2.26 Physical Access for Members. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

2.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for

inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.28 Member Rights. Provider shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed.

2.29 Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.30 Facility Construction or Repair. When applicable for purposes of construction or repair of facilities, Provider shall comply with the provisions in the following acts and/or will include such provisions in any applicable Subcontracts:

- Copeland "Anti-Kickback" Act (18 USC 874, 40 USC 2760) (29 CFR, Part 3)
- Davis-Bacon Act (40 USC 276a-7) (29 CFR, Part 5)
- Contract Work Hours and Safety Standards Act (40 USC 327-330) (29 CFR, Part 5)
- Executive Order 1126 of September 14, 1965 entitled, "Equal Employment Opportunity" as amended by Executive Order 11375 of October 13, 1967, as supplemented in Department of Labor Regulations (41 CFR, Part 60).

When Provider's agreement provides funding for both construction and non-construction activities, Provider shall obtain prior written approval from CalOptima before making any fund or budget transfers between construction and non-construction.

2.31 Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

2.31.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

2.31.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

2.31.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

2.31.1.3 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 Sub provision 13.1.2 herein; and

2.32.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

2.33.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

2.34.1.6 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.

2.31.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

2.31.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

2.31.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

2.32 Lobbying Restrictions and Disclosure Certification. Provider shall complete and submit the lobbying disclosure form required by federal law, when applicable.

2.32.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

2.32.2 Certification and Disclosure Requirements

2.32.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment E, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 2.32.3 of this provision.

2.32.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment E-1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 2.30.3 of this provision if paid for with appropriated funds.

2.32.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 2.30.2.2 herein. An event that materially affects the accuracy of the information reported includes:

2.32.2.3.1 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;

2.32.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

2.32.2.3.3 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.

2.32.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 2.30.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

2.32.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 2.30.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

2.32.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal,

amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2.33 Qualifications of Provider's Agents. Provider shall verify that the qualifications of all Provider's Agents providing Covered Services under this Contract comply with the requirements of this Contract, CalOptima Policies, and DHCS guidance. In addition, for Provider's Agents that enter into Members' homes or have face-to-face contact with Members, Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. Provider shall comply with all applicable laws in conducting background investigations, and shall exclude unqualified Agents from providing services under this Contract.

2.34 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to CalOptima Health Networks the same terms regarding Provider performance, duties and obligations and rates for Ancillary Services provided to CalOptima Members enrolled in Health Networks as are set forth in this Contract, and to extend to the County of Orange the same terms regarding Provider performance, duties and obligations, and rates for Ancillary Services as are set forth in this Contract.

2.35 Whole Child Model Program Compliance. If Provider is a CCS authorized provider, then in the provision of CCS Services to CalOptima Members, the 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.

2.36 CCS Provider Compliance.

2.36.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.36.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.36.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.36.2.2 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.

2.37 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.38 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.39 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from

CalOptima for such Covered Services. Upon submission of a Clean Claim or invoice, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C.

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies Procedures as may be amended from time to time.

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 or invoices for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.2 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies related to the CalOptima Programs and/or this Contract. Additional procedures related to claims processing and payment are set forth in the attached CalOptima Program Addenda.

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider by other parties. Use of a billing agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.4 Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Provider notified of denial pursuant to CalOptima Policies and applicable Federal and/or State laws and regulations.

4.5 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.5.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.5.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract.

4.5.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

4.5.4 Upon receiving notice of Provider invoicing or balance billing a Member for Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.5.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.6 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider

acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

4.6.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this contract.

4.6.2 Payments made for services provided to a Member that is subsequently determined to have not be eligible on the date of service.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Insurance Requirements

5.2.1 Professional Liability:

If providing Professional Services under this contract, the Provider at its sole cost and expense, shall maintain a Professional Liability Insurance policy covering itself and any Subcontractors with minimum limits as follows:

Professional Liability providing Covered Services: $1,000,000 per incident/$2,000,000 aggregate

5.2.2 Commercial General Liability/Commercial Automobile Liability:

Provider, at its sole cost and expense shall maintain a Commercial General Liability and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability: $1,000,000 per occurrence/$2,000,000 aggregate

(Including Personal Injury)

Commercial Automobile Liability: * $1,000,000 Combined Single Limit

Additional insured wording is required on both policies as well as primary and non-contributory wording and Waiver of Subrogation. Additional Insured wording to include: Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

*(Charter-party carriers of passengers:)

If applicable, Provider shall comply with the Public Utilities Commission (PUC) General Order No. 115-G, which requires higher levels of insurance for charter-party carriers of passengers and is based on seating capacity as follows:

$1,500,000 if seating capacity is 8-15

$5,000,000 if seating capacity is over 15 unless otherwise amended by future regulations.

In the case of a charter-party carrier with seating capacity of 7 or less, CalOptima will require $1,000,000 Combined Single Limit.

5.2.3 Workers' Compensation:

Provider, at its sole cost and expense shall maintain a Workers' Compensation Insurance policy as required by the State of California with minimum limits as follows:

Employers' Liability Insurance:

$1,000,000 Bodily injury each accident

$1,000,000 Bodily injury policy limit

$1,000,000 Bodily injury each employee

Waiver of Subrogation wording is required and to include:

Orange County Health Authority, a public agency; DBA: Orange Prevention and Treatment Integrated Medical Assistance; DBA: CalOptima, CalOptima Foundation, including its officers, officials, directors, employees, agents, and volunteers.

5.2.4 Commercial Crime:

If applicable, Provider, at its sole cost and expense shall maintain a commercial crime policy covering theft and dishonesty, forgery and alterations, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property as follows:

Commercial Crime Insurance: $1,000,000 per occurrence

5.2.5 Cyber and Privacy Liability Insurance:

If applicable, Provider shall maintain the following minimum coverages for such length of time as necessary to cover any and all claims:

Cyber and Privacy Liability Insurance: $1,000,000 each coverage (including Privacy and Network Liability;

Internet Media Liability;

Business Interruption and Expense;

Data Extortion;

Regulatory Proceeding; and Data Breach Notification & Credit Monitoring)

5.2.6 Bonding:

If providing services which require bonding, Provider shall be bonded at amounts usual or customary in Provider's industry and type of service.

5.3 Insurer Ratings.

Such insurance shall be provided by an insurer:

(a) Rated by A.M. Best with rating of A- VII or better; and

(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.4 Captive Risk Retention Group/Self Insured:

Where any of the insurances mentioned by Section 5.2 above are provided by a Captive Risk Retention Group or self-insured, Section 5.3 above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

5.5 Cancellation or Material Change:

The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract. Thirty (30) days prior written notice be given to CalOptima in the event of cancellation.

5.6 Certificates of Insurance:

Certificates of Insurance of the above insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

5.7 Subcontractors:

Provider shall require each of its Subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

5.8 Failure or refusal to maintain or produce proof of Insurance:

If Provider fails or refuses to maintain or produce proof of the insurance required by Section 5.2, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect Provider's right to be paid for its time and materials expended prior to notification of termination. Provider waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of Insurance by CalOptima.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, CDA or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, CDA or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Records Retention. The Provider shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Provider furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.3 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Federal and State laws concerning confidentially and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.4. Confidentiality of Member Information. Provider agrees to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information. Provider further agrees:

6.4.1 Health Insurance Portability and Accountability Act (HIPAA). Provider shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Provider shall comply with HIPAA requirements as currently established in CalOptima Policies. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.4.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.4.3 Declaration of Confidentiality. If Provider and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Provider and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC (MRMIB) and/or CMS, as applicable.

6.5 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through **June 30, 2022**. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, permits and certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements, and Provider shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90)

days prior written notice to the other party as provided herein.

7.7 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the Government Contract(s) or the Government Agencies' policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Provider as soon as practicable.

7.8 Approval By and Notice to Government Agencies. Provider acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Provider shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Provider acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Provider agrees to cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits, as well as Provider's response to the CalOptima's Request for Proposal (RFP), if applicable, and any further information or clarification submitted as part of the RFP process, and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder. In the event of any inconsistency between the RFP and this Contract, the terms and provisions of this Contract shall govern and control.

@@Provider@@_Medi-Cal_Accompaniment_@@CM-ID#@@
Back to Agenda

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

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

9.6 Independent Contractor Relationship. CalOptima and Provider agree that the Provider and any agents or employees of the Provider in performance of this Contract shall act in an independent capacity and not as officers or employees of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees of Provider and not employees of CalOptima. Provider shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Provider hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Certified or Registered mail, return receipt requested, postage prepaid to the address set out below. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Provider:

_____
Name

_____
Title

_____
Address

_____

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said

party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

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

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective on @@effective date@@ (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Provider	**CalOptima**
Signature	Signature
Print Name	Print Name
Title	Chief Operating Officer Title
Date	Date

ATTACHMENT A

CONTRACTED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 CalOptima Medi-Cal Program. Provider shall furnish Covered Services to eligible CalOptima Direct Members enrolled in the CalOptima Medi-Cal Program.

ARTICLE 2
SERVICES

2.1 Scope of Work. "Covered Services" as referred to in this Contract means accompaniment services, delivered In-Person or via Phone/Telehealth, for Enhanced Care Management (ECM) as described below:

2.1.1 Accompaniment Services.

2.1.1.1 Provider shall provide accompaniment services to ECM Members for medically necessary appointments in a timely manner as approved and requested by CalOptima, as follows:

2.1.1.1.1 Outreach to an ECM Member in advance of a scheduled appointment to coordinate the provision of accompaniment services, including to confirm the appointment date and time, and to provide information on accompaniment process, what to expect at the appointment, and identification of potential questions.

2.1.1.1.2 On a case-by-case basis, as requested by CalOptima, discuss any special instruction with an ECM Member in advance of an appointment.

2.1.1.1.3 Contact an ECM Member the business day prior to the appointment as a reminder and for confirmation of the appointment.

2.1.1.1.4 Provide same-day services to an ECM Member who needs accompaniment to an unplanned service, such as urgent care and pharmacy.

2.1.1.1.5 Meet an ECM Member at a clinical provider office and attend an appointment with the ECM Member at clinical provider office, as requested by CalOptima and provide an update regarding the appointment visit to CalOptima.

2.1.1.2 Provider understands that ECM Members are expected to arrange their own transportation or request CalOptima to provide non-medical transportation to the appointment. In the latter case, Provider may either accompany an ECM Member in the vehicle that is driven by CalOptima's non-medical transportation vendor by meeting an ECM Member at their preferred location, or meet the ECM Member at the clinical provider office. Provider shall not drive an ECM Member to the appointment or allow an ECM Member to drive the Provider to the appointment.

2.1.1.3 CalOptima will identify ECM Member for accompaniment services for a specific appointment and notify Provider.

2.1.1.4 Provider shall provide accompaniment(s) as set forth in this Attachment within Orange County. Provider agrees to provide accompaniment(s) outside of Orange County as requested by CalOptima on a case by case basis.

2.1.1.5 On a case-by-case basis, CalOptima may request to support the ECM Member and provide accompaniment beyond business hours including hours falling during weekends.

2.1.1.6 If requested by CalOptima and with ECM Member's consent, Provider shall send to CalOptima, no later than two (2) business days following the date of the appointment, a summary report of the discussion, questions raised, next appointment (if any), next steps for the ECM Member, and any referrals for follow-up by CalOptima. CalOptima will provide a standard form that Provider will be required to complete.

2.1.1.7 Provider shall participate in ECM Care Team meetings and in implementing the ECM Member's care management plan, as requested by CalOptima. CalOptima will notify Provider and conduct ECM Care Team meetings outside of the ECM Member appointments.

2.1.1.8 If the clinical office visit is to be conducted through telehealth means, Provider may provide the accompaniment services either in person with the ECM Member at the Member's preferred location, or by coordinating the telehealth visit as a conference call between the ECM Member, the clinical provider, and Provider, along with a language interpreter if required.

2.2 DHCS Requirements for ECM. Provider understands that CalOptima, serving as an ECM Provider through CalOptima Direct, is subject to the DHCS requirements for an ECM provider. As a contracted Provider of CalOptima for the provision of ECM accompaniment services, Provider agrees to comply with, and be bound by, the terms, conditions, and requirements set forth in Addendum 2 of this Contract, applicable CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, and the DHCS-CalOptima ECM and Community Supports Contract.

Remainder of this page intentionally left blank

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICE

1. CALOPTIMA DIRECT MEMBERS

1.1 CalOptima Responsibilities. CalOptima shall provide Members enrolled in CalOptima Direct (COD) with face-to-face language and sign language interpretation services to ensure effective communication with Providers. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for COD Members in accordance with the procedures set forth herein.

1.2 Request for Interpretation Services. To request these interpretation services Provider shall, at least one week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500 to be connected with the Cultural and Linguistic (C&L) Coordinator. The following information will be needed at the time of the request:

a. Member name and ID, date of birth and telephone number;

b. Name and phone number of the care taker, if applicable;

c. Language or sign language needed;

d. Date and time of the appointment;

e. Address and telephone number of the facility where the appointment is to take place;

f. Estimated amount of time the interpretation service will be needed; and

g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

1.3.1 C&L Coordinator. Provider shall make the request at least one week before the scheduled appointment. Provider shall communicate with the CalOptima C&L Coordinator. CalOptima C&L Coordinator will make the best effort to secure an interpreter within 72 hours of a request, and will confirm to the Provider and Member of the result of this effort.

1.3.2 Appointment Changes. If there is any change with the appointment, Provider shall contact CalOptima C&L Coordinator, at least 72 hours before the scheduled appointment.

1.3.3 Provider Obligation For Cost. If Provider fails to communicate with CalOptima C&L Coordinator in a timely manner (less than 72 hours before the appointment), Provider will have to incur the cost of an urgent interpretation service request.

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima the following amounts:

I. Medi-Cal Program Reimbursement

Accompaniment Services Compensation

For Medi-Cal Members, CalOptima shall reimburse for Covered Services as follows:

HCPCS Code	Modifier	Type of Service	Unit of Service (UOS)	Unit Rate
G9012	U2	In-Person: Provided by Non-Clinical Staff	15 Minutes equals 1 UOS; Multiple UOS allowed	[redacted]
G9012	U2, GQ	Phone/Telehealth: Provided by Non-Clinical Staff.	15 Minutes equals 1 UOS; Multiple UOS allowed	[redacted]

- For In-Person services (HCPCS G9012/Modifier U2), Provider's start time begins when face-to- face is initiated with Member and shall end once face-to-face time with Member concludes.
- For Phone/Telehealth (HCPCS G9012/Modifier UD, GQ), Provider's start time begins when Member answers the call and shall end once the communication with Member concludes.
- Unless specified otherwise in this contract, Medi-Cal billing rules and payment policies and guidelines for billing and payment will apply.
- Services not contained in the above fee schedule are not reimbursable.
- Claims shall be billed on a CMS 1500 claim form or billed electronically (EDI).

ATTACHMENT D

DISCLOSURE FORM

@@Provider@@
Name of Provider

The undersigned hereby certifies that the following information regarding **@@Provider@@** (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____

Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ATTACHMENT 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.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT E - 1

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:
contract grant cooperative agreement loan loan guarantee loan insurance	bid/offer/application initial award post-award	initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (Check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC

ADDENDUM 1

MEDI-CAL PROGRAM

The following additional terms and conditions apply to items and services furnished to CalOptima Direct Members under the CalOptima Medi-Cal Program. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

1. Records Retention. Provider shall maintain and retain all records of all items and services provided Members for a term of at least ten (10) years from the final date of the contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima, and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.

   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

2. Access to Books and Records. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination and/or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract for provision of services to CalOptima Medi-Cal Members due to fraud.

3. Form of Records. Provider's and its Subcontractors' books and records shall be maintained in accordance with the general standards applicable to such book or record-keeping.

4. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member

of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation.

5.1 Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Contract or Subcontracts entered into under this Contract. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its subcontractor's possession, in accordance with the DHCS Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

5.2 In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2 If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.3 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. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

6. Downstream Contracts. In the event that Provider is allowed to subcontract for services under this Contract, and does so subcontract, then Provider shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Medi-Cal Policies. Covered Services provided under this Contract shall comply with all applicable Medi-Cal Managed Care Division (MMCD) Policy Letters.

8. Medi-Cal Credentialing. If Provider is of a provider type that is not able to enroll in Medi-Cal through DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

9. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

10. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Provider and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Provider's obligations under this Contract. Provider and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

    Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Provider from unauthorized disclosure. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Provider is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider:

    10.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

    10.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

    10.3 will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

    10.4 will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

11. Debarment Certification. By signing this Contract, the Provider agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

    11.1 By signing this Contract, the Provider certifies to the best of its knowledge and belief, that it and its principals:

        11.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

        11.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

11.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 12.1.2 herein; and

11.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

11.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

11.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

11.2 If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to CalOptima.

11.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

11.4 If the Provider knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

12. DHCS Directions. If required by DHCS, Provider shall cease specified activities for CalOptima Members, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

13. Lobbying Restrictions and Disclosure Certification.

13.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

13.2 Certification and Disclosure Requirements

13.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 13.3 of this provision.

13.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 13.3 of this provision if paid for with appropriated funds.

13.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 13.2.2 herein. An event that materially affects the accuracy of the information reported includes:

13.2.3.1 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;

13.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

13.2.3.3 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.

13.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 13.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

13.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 13.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

13.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. Additional Subcontracting Requirements.

14.1 Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

14.1.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

14.1.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later.

14.2 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

14.2.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

14.2.2 Subcontract or its amendments are subject to DHCS approval as provided in the DHCS Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract.

14.2.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 20 of this Addendum 1.

14.2.4 An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.21 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Addendum 1.

14.2.5 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 15 of this Addendum 1.

14.2.6 An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 14.1 of this Addendum 1.

14.2.7 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 15 of this Addendum 1.

14.2.8 An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the DHCS Contract or the Contract for

any reason, in accordance with Section 18 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

14.2.9 An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.5 of the Contract.

14.2.10 An agreement to notify DHCS in the manner provided in Section 7.8 of the Contract in the event the Subcontract is amended or terminated.

14.2.11 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.15 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.14 or the Contract.

14.2.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract.

14.2.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.11 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

14.2.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 24 of this Addendum 1 and Section 6.4.3 of the Contract.

14.2.15 An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.5 of the Contract.

14.2.16 An agreement for the establishment and maintenance of and access to administrative records as set forth in Section 6.2 of the Contract and Sections 1 and 3 of this Addendum 1.

14.2.17 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

14.2.18 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.4.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

15. State's Right to Monitor. Provider shall comply with all monitoring provisions of this Contract and the DHCS Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS. Without limiting the foregoing, CalOptima and authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. The monitoring activities will be either announced or announced. Staff designated by authorized State agencies will have access to all security areas and the Provider will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

16. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

17. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Provider agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

18. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's DHCS Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor DHCS Contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

19. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

20. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Provider or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

21. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation Provision".

22. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

23. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

24. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

ADDENDUM 2

DHCS REQUIREMENTS FOR ENHANCED CARE MANAGEMENT

The following additional terms and conditions apply to ECM-related Covered Services under this Contract that are furnished to CalOptima Direct Members enrolled in the CalOptima Medi-Cal Program. Provider is subject to the requirements below.

1. Provider Experience and Qualifications

   1.1 Provider shall be experienced in serving the ECM Population(s) of Focus it will serve and shall have experience and expertise with the Covered Services it will provide under this Contract.

   1.2 Provider shall comply with all applicable State and federal laws and regulations and all ECM program requirements in the DHCS CalOptima ECM and Community Supports Contract and associated guidance.

   1.3 Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities set forth in Attachment A of this Contract including accompanying Members to critical appointments when necessary. Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

   1.4 To the extent applicable to the provision of Covered Services under this Contract, Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each ECM Member.

   1.5 To the extent applicable to the provision of Covered Services under this Contract, Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of an ECM Member care plan that can be shared with other Providers and organizations involved in each ECM Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

2. Medi-Cal Enrollment/CalOptima's Vetting Process

   2.1 If a State-level enrollment pathway exists, Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS APLs including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment

   2.2 If APL 19-004 does not apply to the Provider, the Provider shall comply with CalOptima's process for vetting the Provider, which may extend to individuals employed by or delivering Covered Services under this Contract on behalf of the Provider, to ensure the Provider can meet the capabilities and standards required for the provision of Covered Services under this Contract.

3. Identifying Members for ECM. Provider is encouraged to identify Members who would benefit from ECM and send a request to CalOptima, to determine if the Member is eligible for ECM, consistent with CalOptima's process for such request.

4. Lead Care Manager. Provider understands that upon initiation of ECM, CalOptima shall ensure each assigned ECM Member has a Lead Care Manager who interacts directly with the ECM Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), specialty mental health services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health (SDOH) needs, regardless of setting.

   4.1 To the extent applicable to the provision of Covered Services under this Contract, Provider agrees to fully cooperate and coordinate with an ECM Member's assigned Lead Care Manager.

5. Process for Changing ECM Providers

5.1 Provider understands that CalOptima shall: (i) Advise the ECM Member on the process for changing ECM providers, which is permitted at any time; (ii) Advise the ECM Member on the process for switching ECM providers, if requested; and (iii) Implement any requested ECM provider change within thirty (30) calendar days.

5.2 Provider agrees to notify CalOptima if the Provider is informed that the ECM Member wishes to change ECM providers.

6. Provider Staffing. At all times, Provider shall have adequate staff to ensure its ability to carry out responsibilities for the provision of Covered Services to each assigned ECM Member consistent with this Contract, CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS-CalOptima ECM Community Supports Contract and any other related DHCS guidance.

7. Outreach and Member Engagement into ECM. Provider understands that CalOptima shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach. CalOptima shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

7.1 Provider understands that CalOptima shall conduct outreach primarily through in- person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. CalOptima may supplement in-person visits with secure teleconferencing and telehealth, where appropriate, with the Member's consent, and in compliance with CalOptima Policies. CalOptima shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (i) mail; (ii) email; (iii) texts; (iv) telephone calls; and (v) telehealth.

8. Non-Discrimination. Provider shall comply with non-discrimination requirements set forth in State and federal law and this Contract.

9. Initiating Delivery of ECM

9.1 Provider understands that CalOptima shall obtain, document, and manage Member authorization for the sharing of personally identifiable information between CalOptima and the Provider, Community Supports Providers, and other providers involved in the provision of Member care to the extent required by federal law.

9.2 Provider understands that Member authorization for ECM-related data sharing is not required for CalOptima to initiate delivery of ECM unless such authorization is required by federal law.

9.3 When federal law requires authorization for data sharing, CalOptima shall communicate that it has obtained Member authorization for such data sharing to the Provider, and Provider agrees to comply with such Member authorization.

10. Discontinuance of ECM

10.1 Provider understands that CalOptima shall discontinue ECM under the following circumstances: (i) The Member has met their care plan goals for ECM; (ii) The Member is ready to transition to a lower level of care; (iii) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) CalOptima has not had any contact with the Member despite multiple attempts.

10.2 Provider understands that when ECM is discontinued, or will be discontinued for the Member, CalOptima is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. CalOptima shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).

11. ECM Requirements and Core Service Components of ECM

11.1 Provider understands that CalOptima shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in CalOptima Direct. CalOptima shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

11.1.1 To the extent applicable to the provision of Covered Services under this Contract, Provider agrees to fully cooperate and coordinate with CalOptima to ensure the approach is person- centered, goal oriented, and culturally appropriate.

11.2 Subject to all applicable requirements set forth in this Contract (including, but not limited to, subcontracting requirements and the prior written approval of CalOptima), if the Provider subcontracts with other entities to administer ECM functions, the Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth in this Addendum and CalOptima Policies and that its Subcontractors comply with all requirements in the DHCS ECM Provider Standardized Terms and Conditions and the DHCS-CalOptima ECM and Community Supports Contract. Notwithstanding any subcontracting arrangements, the Provider shall remain responsible and accountable for any subcontracted ECM functions related to the provision of Covered Services under this Contract.

11.3 Provider understands that CalOptima shall: (i) Ensure each Member receiving ECM has a Lead Care Manager; (ii) Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources; and (iii) Ensure non- duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources.

11.3.1 To the extent applicable to the provision of Covered Services under this Contract, Provider agrees to follow CalOptima's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

11.4 To the extent applicable to the provision of Covered Services under this Contract, Provider shall collaborate with area hospitals, primary care providers, behavioral health providers, specialists, dental providers, providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care for ECM.

11.5 With the exception of Section 11.5.1 of this Addendum, Provider understands that CalOptima shall provide the following core service components of ECM to each assigned Member, in compliance with CalOptima Policies GG.1354: Enhanced Care Management – Eligibility and Outreach and GG.1353: Enhanced Care Management Service Delivery: (i) Outreach and engagement of Members into ECM; (ii) Comprehensive assessment and care management plan; (iii) Enhanced coordination of care; (iv) Health promotion; (v) Comprehensive transitional care; (vi) Member and family supports; and (vii) Coordination of and referral to community and social support services.

11.5.1 Provider shall provide Covered Services under this Contract in compliance with applicable CalOptima Policies, including CalOptima Policy GG.1353: Enhanced Care Management Service Delivery, to each ECM Member assigned by CalOptima to Provider.

12. Training. Provider shall participate in all mandatory, provider-focused ECM training and technical assistance provided by CalOptima, including in-person sessions, webinars, and/or calls, as necessary. Provider shall ensure that its staff who will be providing Covered Services under this Contract complete the training required by CalOptima and DHCS prior to participating in the provision of such Covered Services.

13. Data Sharing to Support ECM

13.1 If and to the extent necessary to support the Provider's provision of Covered Services under this Contract, CalOptima agrees to provide to the Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

13.1.1 Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned by CalOptima to the Provider for the provision of Covered Services under this Contract;

13.1.2 Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members, as available; and

13.1.3 Reports of performance on quality measures and/or metrics, as requested.

13.2 Provider acknowledges and agrees that encounter and/or claims data are not necessary for the provision of Covered Services under this Contract, and as such will not be provided by CalOptima to the Provider.

14. Claims Submission and Reporting. Provider shall submit claims to CalOptima for the provision of Covered Services under this Contract using the national standard specifications and code sets to be defined by DHCS. In the event Provider is unable to submit claims to CalOptima for Covered Services using the national standard specifications and DHCS-defined code sets, the Provider shall submit an invoice to CalOptima with a minimum set of data elements (to be defined by DHCS) necessary for CalOptima to convert the invoice to an encounter for submission to DHCS.

15. Quality and Oversight. Provider acknowledges that CalOptima will conduct oversight of Provider's participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. Provider shall respond to all requests from CalOptima for information and documentation to permit ongoing monitoring of ECM.

16. Payment for Covered Services

16.1 Provider understands that CalOptima shall pay the Provider for the provision of Covered Services in accordance with this Contract. Provider is eligible to receive payment when ECM is initiated for CalOptima Direct Member for whom the Provider has furnished Covered Services in accordance with this Contract.

16.2 Provider understands that CalOptima shall pay 90 percent of all Clean Claims from Provider within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all Clean Claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

21. Authorize Appropriation of Funds, Unbudgeted Expenditures and a Grant Agreement with Mind OC for Intake and Admissions Coordination Services at the Be Well OC Wellness Center Orange Campus

Contacts

Michael Hunn, Interim Chief Executive Officer, 657-900-1481
Rachel Selleck, Executive Director, Public Affairs, 657-900-1096

Recommended Actions

1. Authorize a Grant Agreement with Mind OC for intake and admissions coordination services at the Be Well OC Wellness Center Orange Campus
2. Appropriate funds and authorize unbudgeted expenditures in the amount of up to $1.0 million from existing reserves to fund the Grant Agreement with Mind OC;
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
4. Authorize the Chief Executive Officer to execute a two-year and eight month Grant Agreement with Mind OC to provide up to $1.0 million to allow for enhanced intake and admissions coordination services provided to CalOptima Medi-Cal members at the Be Well OC Wellness Center Orange Campus.

Background

On December 6, 2018, CalOptima entered into an agreement with the County of Orange Health Care Agency in an amount up to $11.4 million as a prepayment for behavioral health services to be provided to CalOptima Medi-Cal members. These services are being delivered to members at the Be Well OC Wellness Hub in Orange (Be Well OC). The Campus has served an estimated 2,400 CalOptima members since opening January 25, 2021. To address growing behavioral health care needs while ensuring timely access to service and care of CalOptima members, an intake and admissions coordination need was identified at the Campus. CalOptima is seeking Board approval to fund a grant to support enhanced intake and admissions coordination services provided to CalOptima Medi-Cal members at Be Well OC.

Discussion

Staff recommends CalOptima provide a grant in the amount of up to $1.0 million to address the gap in the intake and admissions coordination process at the Campus. The goal is to ensure CalOptima members receive timely access to services, assessment, and placement into care through an improved intake and coordination process. Staff will monitor and evaluate the grant throughout the full two-year implementation to ensure improvements and access for CalOptima members. The additional eight months allow for necessary grant reporting and tracking activities with Mind OC.

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The cost of coordination includes staffing, training and development, administrative cost, one-time phone system upgrade costs and 10% of indirect cost. In addition, hours of service will include seven days a week with coverage for approximately 10 hours per day. In the second year of the grant additional staff may be added increase coverage to 14 hours per day, seven days a week.

Staff recommends providing a grant in the amount of up to $1.0 million to support addressing the gap in the intake and admissions coordination process at the Campus. This proposal will allow for enhanced intake and admissions coordination services provided to CalOptima Medi-Cal members at the Be Well OC.

Fiscal Impact
The recommended actions are unbudgeted. An appropriation of up to $1.0 million from existing reserves will fund the Grant Agreement with Mind OC for the period of March 1, 2022, through November 30, 2024.

Rationale for Recommendation
CalOptima staff recommends a Grant Agreement with Mind OC for Intake and Admissions Coordination services at the Be Well OC Wellness Center Orange Campus. The grant to Mind OC will support ensuring that CalOptima members are assessed in a timely manner and provided with access to appropriate mental health and substance use disorder services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Board Action
2. Mind OC Be Well OC Wellness Center Orange Campus Intake and Admissions Coordination Grant Agreement

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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Attachment to the February 3, 2022 Board of Directors Meeting – Agenda Item 21

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Medical Group	Address	City	State	Zip Code
Mind OC	NA	18650 MacArthur Blvd., Ste. 220	Irvine	CA	92612

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GRANT AWARD AGREEMENT

BETWEEN

CALOPTIMA

AND

MIND OC

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THIS GRANT AWARD AGREEMENT ("**Agreement**") is made and entered into as of the March 1, 2022 ("**Effective Date**"), by and between Orange County Health Authority, a county organized health system for the County of Orange, California dba CalOptima ("**CalOptima**"), and Mind OC, a California 501(c)(3) non-profit corporation ("**Grantee**"). Mind OC is the non-profit corporation that was formed to support Be Well OC, a mental health and substance use disorder services campus located in the City of Orange for all County residents who are referred for care. CalOptima and Grantee may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a public agency formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

B. CalOptima's mission is to provide individuals enrolled in its benefit programs ("**Members**") with access to quality health care services delivered in a cost effective and compassionate manner.

C. CalOptima has designated certain existing reserve funds to coordinate access, identify placement into care, and provide referrals as necessary to ensure access to timely services and care for Members.

D. Grantee desires to provide support and/or enhanced benefits to Members, in accordance with Grantee's grant project described in Attachment A ("**Grant Project**") described in Grantee's Proposal.

E. CalOptima finds that the Grant Project is a community program that supports and is compatible with CalOptima's mission and desires to assist Grantee in undertaking its project by providing financial support described in Attachment B ("**Grant Award**") in accordance with CalOptima' policies and procedures, subject to Grantee's compliance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties hereto as follows:

I. GRANTEE OBLIGATIONS

1.1 **Grantee Eligibility**. Grantee hereby warrants that it is, and shall remain throughout the term of this agreement, a 501(c)(3) non-profit corporation registered in California.

1.2 **Grantee Activities.** Grantee agrees (i) to diligently pursue the Grant Project, as specified in Attachment A, attached hereto and incorporated herein by this reference, (ii) to use the Grant Award solely for activities as identified in Attachment A, ("**Grant Activities**"), (iii) to expend funds in accordance with this Agreement and all federal, state, and local statutes and regulations, and (iv) to return any grant funds determined to have been improperly paid, in order to avoid forfeiture of the entire Grant Award. In the event of any conflict between the Grant Proposal in Attachment A and the rest of this Agreement, this Agreement, including all Attachments, shall prevail.

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1.3 **Unauthorized Use of Funds**. Grantee shall use Grant Funds consistent with this Agreement and the approved Grant Activities. CalOptima retains the right to recover any and all Grant Award funds if it (or any of its regulators) determines that any portion of the Grant Award was not expended as provided under the terms of this Agreement or applicable federal and state laws, regulations, guidance and/or funding source requirements.

1.4 **Limitations on Subcontracting**. The experience, knowledge, capability, and reputation of Grantee, its directors and employees were a substantial inducement for CalOptima to enter into this Agreement. Grantee shall not contract with any entity to perform the Grant Project without written approval of CalOptima. Grantee shall be fully responsible to CalOptima for the acts and omissions of its subcontractor(s), if any, as it is for the acts and omissions of persons directly employed by Grantee. In the event that CalOptima approves any subcontracting, nothing contained in this Agreement shall create any contractual relationship between any subcontractor(s) and CalOptima. All persons engaged in the work under the Grant Proposal by Grantee will be considered employees of Grantee. CalOptima will deal directly with and make payment hereunder solely to Grantee.

1.5 **Subcontracts.** To the extent that subcontracting is authorized by CalOptima under this Agreement, Grantee shall assure that all subcontracts are in writing and include any requirements of this Agreement that are appropriate to the service or activity and assure that the subcontract shall not terminate legal liability of Grantee under this Agreement.

1.6 **Communications Provisions**. Grantee must comply with CalOptima's Guidelines for Endorsements and Use of CalOptima Name or Logo policy.

1.6.1 **Use of CalOptima name or logo**: Grantee shall submit requests to CalOptima's Strategic Development department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name or logo is required. Upon receipt of a complete request for use of the CalOptima name or logo, CalOptima's Community Relations department shall review and analyze the request with input from appropriate internal departments. For more information or to submit a request, email strategicdevelopment@caloptima.org. The Community Relations department shall submit a request for use of the CalOptima name or logo to the CEO for review and consideration and will notify Grantee in writing after a determination has been made.

1.6.2 **All other uses of CalOptima's name:** Grantees may not use CalOptima's name, including in the title of Grantee's program, without prior written approval from CalOptima.

II. GRANT PAYMENTS

2.1 **Grant Payments.** Payment of the Grant Award to Grantee under this Agreement will be as set forth in Attachment B, incorporated herein by this reference, and shall be payment in full for the Grant Project. Grantee acknowledges and agrees that this is a single Grant Award and that nothing herein obligates CalOptima to any further funding, whether for the Grant Project or future related or unrelated activities. The Parties acknowledge that the source of Grant Award funding is existing reserve funds, and not Department of Health Care Services ("**DHCS**") funds, and as such the payments made hereunder are not subject to DHCS State Contract terms or federal or state claims

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processing requirements. Notwithstanding the foregoing, Grantee acknowledges and agrees that the Grant Award must be used for support and enhanced benefits to CalOptima Medi-Cal Members, and is subject to the terms of this Agreement and CalOptima's policies and procedures, as applicable.

2.2 **Grant Award Use Limitations**. Grantee acknowledges and agrees that the Grant Award may not be used for achievement of milestones that have been previously paid for or will be paid for by the state or federal government or any other source. Further, Grantee acknowledges and agrees that it will not use the Grant Award to reimburse costs or liabilities it incurred prior to the date of the Grant Award.

III. WARRANTIES/COMPLIANCE WITH CALOPTIMA AND REGULATORY AGENCY RULES AND REGULATIONS

3.1 **Compliance with Applicable Laws**. In carrying out the Grant Project, Grantee shall comply with the CalOptima policies and procedures and all other applicable CalOptima policies, as well as all federal, state and local laws, rules, and regulations.

3.2 Health Insurance Portability and Accountability Act (HIPAA) Compliance

3.2.1 Grantee and CalOptima shall comply with Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act and any regulations promulgated thereunder ("**HIPAA Requirements**") in performing their obligations under the Agreement.

3.2.2 If required by HIPAA Requirements, the Parties agree to execute CalOptima's HIPAA Business Associate Agreement, which shall be incorporated into this Agreement, and comply with the terms and conditions thereof.

3.3 Confidentiality of Information

3.3.1 Grantee and its employees, agents, and subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to Grantee, its employees, agents, or subcontractors as a result of this Agreement. Grantee and its employees, agents, and subcontractors shall not use such identifying information for any purpose other than carrying out Grantee's obligations under this Agreement. Grantee and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Grantee shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, including without limitation a finger or voice print or a photograph.

3.3.2 Notwithstanding any other provision of this Agreement, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq*., Welfare and Institutions Code

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Section 14100.2, and any regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Grantee from unauthorized disclosure. Grantee may release Member medical records in accordance with applicable laws pertaining to the release of this type of information. Grantee is not required to report requests for medical records made in accordance with applicable laws. With respect to any identifiable information concerning a Member under this Agreement that is obtained by Grantee, its employees, agents, or subcontractors, Grantee:

(a) Will not use any such information for any purpose other than carrying out the express terms of this Agreement,

(b) Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for medical records in accordance with applicable law,

(c) Will not disclose except as otherwise specifically permitted by this Agreement, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 *et seq*., Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and

(d) Will, at the termination of this Agreement, return all such information to CalOptima or maintain such information according to written procedures sent to the Grantee by CalOptima for this purpose.

IV. RECORDS AND REPORTS

4.1 **Maintain Complete Books and Records.** Grantee shall create and maintain such books and records relating to the Grant Activities performed under this Agreement as required by applicable laws and CalOptima policies and procedures. All financial records shall be maintained in accordance with generally accepted accounting principles ("**GAAP**"). Records generated in the course of carrying out this Agreement shall be maintained for ten (10) years from the date of the grant award, or the date of the completion of any audits related to this Agreement, whichever is later. Grantee shall provide CalOptima or its designated agents, within ten (10) calendar days of a written request, information or copies of records necessary to verify and substantiate compliance with the terms of this Agreement. Grantee shall pay all duplication and postage costs associated with any audits and/or reviews necessary to ensure compliance with this Agreement or CalOptima's regulatory requirements. This Section 4.1 shall survive the termination of this Agreement.

4.2 **Reports.** Grantee shall submit all reports in accordance with Attachment C, "Grant Semi-Annual, Annual and Final Progress Report Schedule," attached hereto and incorporated herein by this reference.

4.3 **Audit.** CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant

Award within thirty (30) days of the notice of such improper expenditures. Grantee shall be entitled to challenge any audit finding through appealing through CalOptima's grievance process.

V. INSURANCE AND INDEMNIFICATION

5.1 **Grantee Comprehensive General Liability ("CGL")/Automobile Liability**. Grantee at its sole cost and expense shall maintain such policies of comprehensive general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers, employees, agents, and representatives against any claim or claims for damages arising by reason of (a) personal injuries or death occasioned in connection with the carrying out the project, (b) the use of any property of the Grantee, and (c) Grant Activities performed in connection with the Agreement, with minimum coverage of one million dollars ($1,000,000) per incident/three million dollars ($3,000,000) aggregate per year.

5.2 **Workers Compensation Insurance.** Grantee at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employer's liability insurance with minimum limits of liability of one million dollars ($1,000,000) per occurrence/one million dollars ($1,000,000) aggregate per year.

5.3 **Insurer Ratings**. Insurance required under this Agreement shall be provided by an insurer:

(a) Rated by Best's Guide Rating with a rating of B or better; and
(b) Admitted to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code Section 12180.7.

5.4 **Captive Risk Retention Group/Self Insured.** Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.5 **Cancellation or Material Change.** The Grantee shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Agreement without prior notification to CalOptima.

5.6 **Certificates of Insurance**. Prior to execution of this Agreement, Grantee shall provide Certificates of Insurance and additional insured endorsements to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and Grantee's coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

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5.7 **Indemnification.** Grantee shall defend, indemnify, and hold harmless CalOptima and its officers, directors, and employees from and against any and all claims (including attorneys' fees and reasonable expenses for litigation or settlement) that are related to or arise out of the Grantee's negligence, willful performance or non-performance, or breach of any duties or obligations of Grantee arising under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release Grantee from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.8 **Notification of Claims.** CalOptima agrees to promptly notify Grantee of any claims or demands which arise and for which indemnification or Grantee's duty to defend hereunder is sought.

5.9 **Termination.** The terms of this Article V shall survive the termination of this Agreement.

VI. TERM AND TERMINATION

6.1 **Term of Agreement.** This Agreement will commence on the Effective Date and will remain in effect up to and including November 30, 2024, or completion of the Grant Project, whichever occurs first.

6.2 **Termination.** If Grantee fails to fulfill any of its duties and obligations under this Agreement, including but not limited to: (i) committing acts of unlawful discrimination; (ii) engaging in prohibited marketing activities; and, (iii) committing fraud or abuse relating to any obligation, duty or responsibility under this Agreement (such as falsifying data in any semi-annual, annual or final report; failing to maintain eligible status (non-profit in good standing), paying for services to non-Medi-Cal Members out of grant funds, etc.), CalOptima may terminate this Agreement for cause pursuant to Section 6.3.

6.3 **Termination for Cause**. Notwithstanding and in addition to any other provisions of this Agreement, CalOptima may terminate this Agreement for cause effective upon thirty (30) calendar days' prior written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 6.2. Grantee may appeal CalOptima's decision to terminate the Agreement for cause by filing a complaint pursuant to CalOptima policies and procedures. Grantee shall exhaust this administrative remedy, including requesting a hearing if permitted under CalOptima policies and procedures, for any and all Grantee complaints before commencing any civil action.

CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

6.4 **Automatic Termination.** This Agreement shall terminate automatically if the DHCS State Contract between Cal Optima and DHCS is terminated.

6.5 **Bankruptcy.** CalOptima or Grantee may terminate this Agreement with thirty (30) days' written notice to the other Party in the event (i) a petition is filed in a court of record jurisdiction

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to declare either Party bankrupt or for reorganization under the bankruptcy laws of the United States or any similar statute of a state of the United States, or (ii) if a trustee in bankruptcy or a receiver is appointed for such Party, and such petition, trustee, or receiver, as the case may be, is not dismissed within one hundred and twenty (120) days thereof.

VII. GENERAL PROVISIONS

7.1 **Interpretation of Agreement Language.** CalOptima has the right to final interpretation of the Agreement language when disputes arise. Grantee has the right to appeal disputes concerning Agreement language to CalOptima.

7.2 **Waiver.** Any failure of a Party to insist upon strict compliance with any provision of this Agreement shall not be deemed a waiver of such provision or any other provision of this Agreement. To be effective, a waiver must be in writing that is signed and dated by the Parties.

7.3 **Assignment.** Neither this Agreement nor any of the duties delegated herein shall be assigned, delegated, or transferred by Grantee without the prior written consent of CalOptima. CalOptima may assign this Agreement and its rights, interests, and benefits hereunder to any entity that has at least majority control of CalOptima or to any entity whose financial solvency has been approved by Grantee, which approval shall not be unreasonably withheld. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state and federal agencies.

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

7.5 **Integration of Entire Agreement.** This Agreement contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations, or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement that are not expressly set forth in this Agreement are null and void and of no further force or effect. All attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein.

7.6 **Independent Agreement.** Nothing in this Agreement shall affect any other contractual relationships between the Parties, such as an agreement for the provision of medical services to Members. No monies paid under this Agreement may be used for the provision of services that are payable under a different contract between the Parties, or for any other purpose beyond the Grant Project as set forth in Attachment A.

7.7 **Invalidity or Unenforceability.** The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

7.8 **Amendment.** CalOptima may amend this Agreement immediately upon written notice to Grantee in the event such amendment is required in order to maintain compliance with applicable state or federal laws. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the Parties.

7.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

7.10 **Choice of Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of California. The Parties consent to the jurisdiction of the California Courts with venue in Orange County, California.

7.11 **Force Majeure.** Both Parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Agreement as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war, but excluding labor disputes, (a "**Force Majeure Event**") provided such Party uses commercially reasonable efforts to mitigate its effects and gives prompt written notice to the other Party. The time for the performance shall be extended for the period of delay or inability to perform due to such occurrences up to a period of ten (10) days at which time the Party unaffected by the Force Majeure Event may immediately terminate this Agreement upon written notice to the other Party without liability.

7.12 **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Agreement, and no implication shall be drawn against any Party by virtue of the drafting of this Agreement.

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

7.14 **No Liability of County of Orange.** As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Grantee hereby acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and that the County of Orange, State of California, shall have no obligation or liability therefor.

7.15 **Non-liability of Officials and Employees of CalOptima**. No official or employee of CalOptima shall be personally liable to Grantee in the event of any default or breach by CalOptima, or for any amount that may become due to Grantee, or any obligation under the terms of this Agreement.

7.16 **Time of Essence**. Time is of the essence in the performance of this Agreement.

7.17 **Authority to Execute**. The persons executing this Agreement on behalf of the Parties warrant that they are duly authorized to execute this Agreement, and that by executing this Agreement, the Parties are formally bound.

7.18 **Counterparts**. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

7.19 **Notices.** All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such Party's address as set forth below or such other address provided by notice.

To: CalOptima
Attention: CEO
C/O: Strategic Development
505 City Parkway West
Orange, California 92868

To: Grantee
_____
_____
_____
_____

[SIGNATURES ON FOLLOWING PAGE]

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VIII: SIGNATURES

IN WITNESS WHEREOF, the Parties have, by their duly authorized representatives, executed this Agreement, to be effective the date first written above:

FOR GRANTEE:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Michael Hunn
PRINT NAME	PRINT NAME
_____	Interim Chief Executive Officer
TITLE	TITLE
_____	_____
DATE	DATE

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ATTACHMENT A

Grant Project

A. Organization Information

Organization Name: Mind OC

Address: 18650 MacArthur Blvd. Ste 220 Irvine, CA 92612

Organization Type: 501(c)(3) non-profit

Organization Description: In Orange County a collective impact collaborative launched Be Well OC in 2018. Be Well OC brings together a robust, community-based, cross-sector strategy – public, private, academic faith and other – to create a countywide, coordinated ecosystem to support optimal mental health. With the intentionally coordinated system, created in public-private partnership, the community will benefit from best-in-class care. Mind OC was established as a California non-profit in 2019 to help lead the Be Well OC initiative.

The first of three Be Well OC mental health and wellness campuses was unveiled in January 2021 located in the City of Orange. The state-of-the-art facility is providing best-in-class mental health and substance use disorder services to all County residents who are referred for care. The facility features a crisis stabilization center for mental health needs, and the County's first recovery station for substance use disorders. Other services include withdrawal management, adult residential treatment (transitional, co-occurring and substance use), and an integrated support center.

Organization Mission Statement (optional): Vision: Be Well OC will lead the nation in optimal mental health and wellness for all residents of Orange County. Be Well OC brings a robust, community-based, cross sector strategy – public and private academic, faith-based and others – to create a community-wide coordinated ecosystem to support optimal mental health.

Tax Status: 501 (c) (3)

CEO/Executive Director Contact

Name: Marshall Moncrief
Title: CEO
Email Address: marshall.moncrief@mind-oc.org
Phone Number: 949-400-4157
Office Address: 18650 MacArthur Blvd. Ste 220 Irvine, CA 92612

Primary Contact

Name: Karen W. Linkins PhD
Title: COO
Email Address: karen.linkins@mind-oc.org

Phone Number: 480-299-5900
Office Address: 18650 MacArthur Blvd. Ste 220 Irvine, CA 92612

B. Project Information

Project Title: Be Well OC Orange Campus Intake & Admissions Coordination			
Project Duration (Years): Project duration must not exceed three (3) years.	3 Years	Anticipated Project Start Date:	March 1, 2022
Project Budget:	$1,000,000	Anticipated Project End Date:	February 29, 2024
Total Grant Amount Requested:	$1,000,000	Project Term (Months):	33 months

Brief Proposal Summary:
Please provide a one-paragraph general description of the project and its purpose. (150 word limit)
The innovative system of care at the Be Well Orange Campus spans seven different clinical programs across the mental health and substance use treatment continuum. While the Campus was envisioned and designed to meet the needs of the whole community, there is a focus and commitment to meeting the needs of our most vulnerable community members receiving benefits and care through Medi-Cal. After nearly a year of operational experience, the Campus requires a robust intake and admissions coordination capability to best meet the needs of the community and ensure excellence in access, assessment, placement into care, and referrals when indicated.

Statement of Need:
Please describe the need for the proposed project and services that you will be providing to CalOptima members, the estimated number of CalOptima members affected and how you arrived at this number; describe the community or geographical area to be served. Provide data and information to support the need and focus on local data. (300 word limit)
The innovative system of care at the Be Well Orange Campus spans seven different clinical programs across the mental health and substance use treatment continuum. While the Campus was envisioned and designed to meet the needs of the whole community, there is a focus and commitment to meeting the needs of our most vulnerable community members receiving benefits and care through Medi-Cal. After nearly a year of operational experience, the Campus requires a robust intake and admissions coordination capability to best meet the needs of the community and ensure excellence in access, assessment, placement into care, and referrals when indicated. Mind OC is positioned to provide the intake coordination function for the campus to alleviate the burden on the service provider partners. The intake and admissions team will work closely and collaboratively with OC Links and other County and Cal Optima functions necessary to coordinate appropriate placement into care.

Project Description:
Please provide a detailed description of how this project will address the identified unmet need in the community. This detailed description should explain the goals of the project, how they will be achieved, how progress and success will be measured, how and what services you will provide to CalOptima members, how you will confirm services are provided to CalOptima members, and what outcomes/results you expect to achieve. Describe any collaborations and partnerships with other

organizations for the services you are proposing (1,000 word limit).
A licensed clinician serves as the Intake Supervisor responsible for day-to-day operations and works alongside the counselors as needed to meet scheduling requirements. This role and the service reports to the Executive Director of Operations. Certified Alcohol and Drug Counselors (CADC) are cost effective and clinically appropriate. Expenses include initial one-time phone system upgrades, as well as ongoing infrastructure and training expenses.

Evidence Supporting Approach:

Please provide evidence or information regarding promising practices to support the efficacy of your proposed project. You may include links to reference materials in your response. (300 word limit)
It is axiomatic that an effective intake process is essential for successfully engaging individuals with mental health and substance use services. Ensuring that clients seeking or referred for services are able to be effectively connected to the appropriate program supports engagement, retention, and outcomes. Centralizing the intake process for a multi-program, multi-provider campus also supports accurate data capture and reporting to promote client and population health evaluation and improvement.

Outreach and Education Strategy:

Explain how you will promote and connect CalOptima members to your proposed services. Describe how you will specifically track the number of CalOptima members reached through your outreach plan. (500 word limit)
This program will build on the successful outreach and education strategies that have helped launch the Be Well Orange Campus. We will continue to work with referral partners such as hospitals, law enforcement, and providers to ensure they are aware of the available services. With this new more robust intake process, we expect to be able to smooth the intake process for clients and referral partners alike, ensuring that clients are more effectively connected to the right care at the right time. The Intake team will be a vital part of the ongoing development and execution of the overall Be Well Orange Campus outreach plan.

To track CalOptima members and others reached through outreach and engagement efforts we will continue to work with the Campus service providers, Exodus and Telecare, to collect relevant data on each client. We will continue to synthesize this data and report aggregate Campus data in a monthly dashboard. Additionally, recognizing that some clients served by the intake team may not ultimately be served by either campus providers, we will track all contacts with the intake team in our customized Salesforce system, noting whether clients were admitted to campus services or connected with other programs
.

Sustainability Plan:

Please describe how the project will be sustained after grant support has ended. Please note that these grant funds are one-time only awards and are not intended to support long-term staffing plans. (300 word limit)
Sustainability planning is central to the work of Mind OC and Be Well. As a successful nonprofit entity, our very survival and ability to meet the needs of our community depends on our ongoing ability to develop viable sustainability plans to continue work begun with temporary grant funding. We believe that this campus intake program is a sustainable model, with this opportunity providing the catalytic seed funding to get the program working efficiently through community and provider outreach, engagement, education, and training. Catalytic funding is crucial for the success of this project. This proposed project fills a funding gap because there are no available funds for these services. However, we anticipate the project will be made sustainable through demonstration of the return on investment of better managing campus intake processes to maximize the resources available through the proper payor channels.

Population Served	
Number of CalOptima Members Currently Served: *How many CalOptima members do you currently provide services to annually?*	Approximately 2,400.
Number of Additional CalOptima Members Served: *How many additional CalOptima members do you expect to provide services to over the course of your project? (Grant awardees must track and report this number quarterly.)*	Approximately 2,400.

Number of Additional CalOptima Members Served Estimate and Tracking Methodology Narrative:
Explain how this number/estimate was derived and how CalOptima members will be identified, tracked and reported. (300 word limit)
During the first year of operations at the Be Well Orange Campus, provider programs have ramped up to serving approximately 200 CalOptima members per month, or an estimated 2,400 members per year. Our planning has concluded that a more robust intake process can support serving an additional 100 CalOptima members per month, for a total of 3,600 per year. Tracking and reporting insurance status and related information is at the core of this intake program and will deepen and strengthen the existing tracking and reporting that currently captures information about clients being served at the Campus, as reported on monthly dashboards.

Age Group Served:
Children (13-18)
Adults (19-64)
Seniors (65+)

Ethnicity/Language Served:
All ethnicities.

CalOptima Threshold Language Served:
All threshold languages.

Geographic Area Served:
Please select all Cities and/or Census-Designated Places (CDP) that apply. There are a total of 34 cities and 6 CDPs in Orange County.
All geographic areas of Orange County, including 34 cities and 6 CDPs.

C. Project Staffing Plan

Project Staffing Plan Narrative:
Please explain how you will identify, track, and report how staffing will be allocated to the project/program. (800 word limit)
This project begins from an understanding that an Intake Supervisor and two Intake Counselors are required to launch the program. We anticipate adding an additional Counselor in phase 2 to support additional hours of service. As detailed in the work plan below, we will develop position descriptions for the roles and then recruit to fill them. Staff will track their time in our HR system, identifying which project it relates to. Any consultants or subcontractors will have project specific scopes of work and invoice against the appropriate

project(s). As appropriate, we will conduct ongoing recruiting and hiring to ensure adequate staff to carry out the necessary activities, allocating qualified staff from other projects as available should the need arise.

Subcontractor(s) Information:
Identify subcontractor(s) by company name, address, contact person, email and telephone number; describe experience working with each subcontractor. If this field is not applicable, please type N/A. (300 word limit)

Dr Robert McCarron, DO
University of California, Irvine
UCIMC, Bldg 3, Rt 88
Irvine, CA 92697
Email: r.mccarron@uci.edu
Phone: (714) 456-3645

Dr, McCarron serves as the Medical Director for Be Well activities, including the Be Well Orange Campus and the Mobile Response program.

D. Project Budget Plan

Project Budget Plan Narrative:
Please provide a description for each proposed line item in your Project Budget. (800 word limit) A licensed clinician serves as the Intake Supervisor responsible for day-to-day operations and works alongside the counselors as needed to meet scheduling requirements. This role and the service reports to the Executive Director of Operations. Certified Alcohol and Drug Counselors (CADC) are cost effective and clinically appropriate. Expenses include initial one-time phone system upgrades, as well as ongoing infrastructure and training expenses.

Phase 1: 7 days per week 8 am to 6 pm
Phase 2: 7 days per week 8 am – 10p

E. Workplan Information

Please list the objectives of your proposed project, the activities that will take place to reach the objectives, and how these activities will be evaluated and assessed. Please include SMART (specific, measurable, achievable, realistic and time-bound) goals and objectives. Grantees will be required to submit quarterly and annual progress reports, as well as a final report, to appraise the progress toward identified objectives in the workplan.

SMART Objectives:

- **Specific:** Who? (target population and persons doing the activity) and What? (action/activity)
- **Measurable:** How much change is expected?
- **Achievable:** Can be realistically accomplished given current resources and constraints
- **Realistic:** Addresses the scope of the project and proposes reasonable programmatic steps
- **Time-bound:** Provides a time frame indicating when the objective will be met

Your measurable objectives must include a numeric (quantitative) value to determine the success of your project. For example, “Our goal is to increase access to dental care for 250 school children per month,” or “This project will result in a 50 percent increase in children receiving fluoride treatments by December 31, 2018.”

***A minimum of three (3) objectives are required for one-year grants. Five (5) objectives are strongly preferred for two- or three-year grants. ***

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1. OBJECTIVE			
Start Date:	3/1/2022	End Date:	5/31/2022

Measurable Objective:
What will you accomplish? (300 word limit)

Staff program with one Intake Supervisor and two Intake Counselors to support Phase 1.

Key Activities:
What specific tasks/activities will be implemented to achieve the objective? (300 word limit)

- Develop position description for Intake Supervisor and Intake Counselor roles
- Recruit, screen and hire licensed Intake Supervisor with background appropriate to fulfill position description
- Recruit, screen and hire two Intake Counselors with background appropriate to fulfill position description

Evaluation Indicators:
How will you measure? (300 word limit)

- Position descriptions created for each role
- Each position posted for recruiting
- Number of qualified respondents for each position
- Qualified candidate hired for each position

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2. OBJECTIVE			
Start Date:	3/1/2022	End Date:	Ongoing (annual review)

Measurable Objective:
What will you accomplish? (300 word limit)

Program staff are appropriately trained with ongoing professional development.

Key Activities:
What specific tasks/activities will be implemented to achieve the objective? (300 word limit)

- Based on position descriptions and program requirements, develop training plan for Intake Supervisor and Intake Counselor roles
- Provide program staff with training described in training plan and professional development that supports the individual, position, and program
- Provide staff with annual performance review, including review of training and development activities completed and needed

Evaluation Indicators:
How will you measure? (300 word limit)

- Training plans developed for each role
- Necessary training completed by each staff member annually
- Performance review completed annually

---

3. OBJECTIVE			
Start Date:	3/1/2022	End Date:	9/30/2022

Measurable Objective:
What will you accomplish? (300 word limit)

All campus programs are accessible to all clients and referral partners via a single phone number.

Key Activities:
What specific tasks/activities will be implemented to achieve the objective? (300 word limit)

- Work with campus providers and County to establish programmatic requirements
- Establish technical requirements
- Modify existing campus phone system to meet technical and programmatic requirements

Evaluation Indicators:
How will you measure? (300 word limit)

- Monthly inbound call volume
- Monthly volume of calls handled by intake team versus calls routed to campus providers or other programs
- Monthly volume of calls resulting in Campus admission

---

4. OBJECTIVE *(optional)*			
Start Date:	3/1/2022	End Date:	6/30/2022

Measurable Objective:
What will you accomplish? (300 word limit)

Adapt and/or augment monthly Campus dashboard to support intake program reporting needs and ensure capture of data and information for quarterly, annual, and final reports.

Key Activities:
What specific tasks/activities will be implemented to achieve the objective? (300 word limit)

- To track CalOptima members and others reached through outreach and engagement efforts we will continue to work with the Campus service providers, Exodus and Telecare, to collect relevant data on each client.
- Work with CalOptima to ensure relevant data elements are captured and reported
- Continue to synthesize data and report aggregate Campus data in a monthly dashboard.
- Adapt existing customized Salesforce system to meet program requirements

Evaluation Indicators:
How will you measure? (300 word limit)

- Monthly dashboard produced and disseminated
- Number of individuals and organizations that the dashboard is shared with

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5. OBJECTIVE *(optional)*			
Start Date:	3/1/2022	End Date:	2/29/2024

Measurable Objective:
What will you accomplish? (300 word limit)

3,600 people served each year through intake and admissions coordination program for Be Well Orange Campus spanning seven programs, delivered by two providers.

Key Activities:
What specific tasks/activities will be implemented to achieve the objective? (300 word limit)

- Establish intake program, with appropriate staffing, training and infrastructure, as described above
- Build on successful outreach and education strategies that have helped launch the Be Well Orange Campus.
- Continue to work with referral partners such as hospitals, law enforcement, and providers to ensure they are aware of the available services.
- Ongoing development and execution of the overall Be Well Orange Campus outreach plan.
- Prepare and disseminate monthly dashboard documenting program services

Evaluation Indicators:
How will you measure? (300 word limit)

- Monthly volume of clients served, including referral source
- Quarterly volume of outreach activities, including number of individuals and organizations reached
- Client and referral partner satisfaction surveys

Budget Plan Mind OC Be Well OC Intake and Admissions												
	YEAR 1				YEAR 2				YEAR 3(optional)			
Expenses	**CalOptima Grant Funds (Requested)**	**In-Kind Support**	**Other Funds**	**Year 1 Total**	**CalOptima Grant Funds (Requested)**	**In-Kind Support**	**Other Funds**	**Year 2 Total**	**CalOptima Grant Funds (Requested)**	**In-Kind Support**	**Other Funds**	**Year 3 Total**
Salary and Benefits	$288,600			$288,600	$366,600			$366,600	$183,300			$183,300
Contract Services (consulting, professional)	$12,000			$12,000	$12,000			$12,000	$6.000			$6.000
Equipment (specify): One-time phone and data system upgrade cost (Year 1)	$15,000			$15,000				$ -				
Supplies												
Printing, Copying and Postage												
Evaluation												
Outreach and Education												
***Other:** Phone, emails, data system, etc.	$3,720			$3,720	$4,920			$4,920	$2,460			$2,460
***Other:** Training and development	$2,325			$2,325	$3,075			$3,075	$1,538			$1,538
Indirect Expenses (no more than 10%)	$32,165			$32,165	$38,660			$38,660	$19,330			$19,330
TOTAL EXPENSES	$353,810			$353,810	$425,255			$425,255	$212,628 -			$212,628

	GRAND TOTAL				For Final Report Only		
Expenses	**CalOptima Grant Funds (Requested)**	**In-Kind Support**	**Other Funds**	**Total**	**Actual Expenditures**	**Variance (Budget less Actual)**	**Variance Explanation (if applicable)**
Salary and Benefits	$838,500			$838,500		$838,500	
Contract Services (consulting, professional)	$30,000			$30,000		$30,000	
Equipment (specify): One-time phone and data system upgrade cost (Year 1)	$15,000			$15,000		$15,000	
Supplies							
Printing, Copying and Postage							
Evaluation							
Outreach and Education							
***Other:** Phone, emails, data system, etc.	$11,100			$11,100		$11,100	
***Other:** Training and Development	$6,938			$6,938		$6,938	
Indirect Expenses (no more than 10%)	$90,155			$90,155		$90,155	
TOTAL EXPENSES	$991,693			$991,693		$991,693	

Staffing Plan
Mind OC
Be Well OC Intake and Admission Project

Staff Name	New Position? (Yes or No)	Job Title	Role on Project	Total Salary	Cost of Benefits and Taxes	% Time on Project	Total Cost of Staff (Salary + Benefits)	Description of Responsibilities/Duties and Qualifications
N/A		Intake Supervisor		$ 93,600.00	$ 23,400.00	100.00%	$ 117,000.00	Licensed clinician responsible for day-to-day operations working alongside the counselors as needed to meet scheduling requirements. Reports to the Executive Director of Operations
N/A		Intake Counselor		$ 62,400.00	$ 15,600.00	100.00%	$ 78,000.00	Certified Alcohol and Drug Counselor (CADC) Supports intake process for clients and referral partners. Conducts assessments with clients seeking services. Assists Supervisor with development and implementation of policies and protocols to ensure timely and appropriate client access to services and maintains appropriate connections with referral sources throughout the community.

N/A		Intake Counselor		$ 62,400.00	$ 15,600.00	100.00%	$ 78,000.00	Certified Alcohol and Drug Counselor (CADC) Supports intake process for clients and referral partners. Conducts assessments with clients seeking services. Assists Supervisor with development and implementation of policies and protocols to ensure timely and appropriate client access to services and maintains appropriate connections with referral sources throughout the community.
N/A		Intake Counselor		$ 62,400.00	$ 15,600.00	100.00%	$ 78,000.00	Certified Alcohol and Drug Counselor (CADC) Supports intake process for clients and referral partners. Conducts assessments with clients seeking services. Assists Supervisor with development and implementation of policies and protocols to ensure timely and appropriate client access to services and maintains appropriate connections with referral sources throughout the community.
N/A		Executive Director of Operations		$ 124,800.00	$ 31,200.00	10.00%	$ 15,600.00	Provides overall direction for operations and programs, supporting Intake Supervisor as needed.
Total				**$ 405,600.00**	**$ 101,400.00**		**$ 366,600.00**	

ATTACHMENT B

GRANT PAYMENT

CalOptima has made a Grant Award to Grantee in the amount of million dollars ($1,000,000), which shall be the maximum amount payable for the Grant Project and which shall be paid following execution of the Agreement in the time and manner set forth below.

Payments: Payments under this Agreement shall be made in one installment. The first payment shall be made following the execution of this Agreement.

Return Funds: Grantee shall refund to CalOptima any funds that are found to not have been utilized in accordance with the requirements of this Agreement. CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures.

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ATTACHMENT C

GRANT SEMI-ANNUAL, ANNUAL AND FINAL PROGRESS REPORT SCHEDULE

Purpose of Grant Reports

In an effort to help ensure successful grant outcomes, CalOptima actively monitors and evaluates grant progress and requires that grantees submit quarterly and annual progress reports as well as a final report. These reports are intended to help both CalOptima and grantee appraise progress toward funding objectives.

Grant Report Requirements

All grant recipients must complete the Grant Report Form provided through CalOptima's grant management system. Please note that successful completion of reports is a condition of grant funding. **Reports that are not submitted via CalOptima's online grant report form will not be accepted.**

Report Submission Schedule

This grant requires the submission of four reports over the duration of the project timeframe (i.e. March 1, 2022 to February 29, 2024) as follows:

- **Semi-Annual Progress Reports**, submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of each project quarter.
    - Specific due dates and Reporting Periods Covered:
        - Semi-Annual Progress Report #1-Due by September 30, 2022, for Reporting Period March 1, 2022 to August 31, 2022
        - Semi-Annual Progress Report #2-Due by September 30, 2023, for Reporting Period March 1, 2023 to August 31, 2023

- **Annual Progress Report,** submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of each grant year of this Grant Agreement.
    - Specific due date and Reporting Period Covered:
        - Annual Progress Report Due by March 30, 2023 for Reporting Period March 1, 2022 to February 28, 2023

- **Final Report,** submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of this Grant Agreement.
    - Specific due date and Reporting Period Covered:
        - Final Report Due by March 30, 2024 for Reporting Period March 1, 2022 to February 29, 2024

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

22. Authorize Amendments to the Children's Hospital of Orange County and CHOC Physician Network Contracts for Health Care Services Reflecting Language Regarding its Pediatric Member Population

Contact

Yunkyung Kim, Chief Operating Officer 714-246-8408

Recommended Action

Authorize the Chief Executive Officer (CEO) to amend the capitated/delegated Children's Hospital of Orange County and CHOC Physician Network Contracts (CHOC) for Health Care Services to add language reflecting the definition of CHOC's member population.

Background & Discussion

Staff requests to amend Children's Hospital of Orange County (CHOC) and CHOC Physician Network (CPN) contracts to add in previously existing language defining their member population as those 21 years of age and under. The applicable language was inadvertently omitted from the CHOC entities' 2019 amended and restated Health Network contracts.

CHOC and CPN have served CalOptima members since 1995 and were originally contracted to serve eligible health network members of all age groups. After conducting a cost analysis in 2006, CHOC and CPN determined that pressures related to market cost changes would no longer allow them to accept eligible members of all age groups. CHOC and CPN requested renewal of their contracts in 2007 based on CalOptima's recognition that their membership was limited to the pediatric only population from that point forward. This enrollment limitation was addressed through an addendum to their contracts and approved by CalOptima's Board of Directors.

To reflect the definition of membership agreed upon by CHOC, CPN and CalOptima, staff requests that the Board authorize amendments to the CHOC and CPN contracts for health care services to add the pediatric only membership language back into the contracts.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

Amendments to the CHOC and CPN contracts will add language back into the contracts that was deliberately included in prior versions to correctly identify the member population served, but inadvertently omitted from the current contracts.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Proposed Amendment to CHOC Hospital Contract
3. Proposed Amendment to CHOC Physicians Network Contract
4. Previous Board Action dated October 19, 2006; "Authorize the Chief Executive Officer to Modify the Existing Contracts with Children's Hospital Orange County (CHOC) and CHOC Physicians Network (CPN) Physician Hospital Consortium (PHC) to establish a Pediatric PHC Serving Members of CalOptima's Medi-Cal and Healthy Families Programs

Board Actions
N/A

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
CHOC Physician's Network and Children's Hospital of Orange County	1120 W. La Veta Ave. Suite 450	Orange	CA	92868

AMENDMENT XI TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT XI TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of _____ by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Children's Hospital of Orange County** ("Hospital"), with respect to the following facts:

RECITALS

A. CalOptima and Hospital have entered into a Contract for Health Care Services ("Contract"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital desire to amend the Contract to include reference to pediatrics-only Health Network to better align the services it provides to CalOptima's Members.

NOW, THEREFORE, the parties agree as follows:

1. The following shall be added to the end of Article 3 "Obligations of Hospital – Administrative" of the Contract:

   "3.47 Special limitations applicable to this contract regarding pediatric-only Health Network Contract exceptions are contained in Addendum II."

2. Addendum II "Pediatrics-Only Health Network Contract Exceptions" shall be added to the Contract and is attached hereto.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **Children's Hospital of Orange County** have executed this Amendment:

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM II

Pediatrics-Only Health Network Contract Exceptions

The following terms and provisions, in addition to the terms and provisions of the Contract, shall apply to Covered Services rendered by Hospital to CalOptima Members. In the event of a conflict between the terms of the Contract and the provisions set forth below, the provision set forth below shall apply:

1. **Definition of Member**. For the purposes of the Health Network, Members shall be limited to persons under 21 years of age, except for those Members who meet the criteria set forth in paragraph 2, as provided for in CalOptima policy.

    a. CalOptima shall adopt policies, procedures and practices to ensure that all Members assigned to Health Network shall meet the criteria of this section.

    b. Health Network shall notify CalOptima promptly of any Member that it believes has been assigned incorrectly to Health Network.

    c. CalOptima shall investigate, and as warranted correct, any erroneous Member assignments identified by Health Network.

2. **Membership Exception for Those 21 Years of Age and Older.** A Member shall remain in Health Network beyond the Member's twenty-first (21st) birthday if the Member meets all of the following criteria:

    a. Member does not select another Health Network;

    b. Member is diagnosed with one (1) of the following CCS-Eligible Conditions:

        i. Cystic Fibrosis;

        ii. Rare metabolic disorders, not including Phenylketonuria (PKU);

        iii. Spina Bifida; or

        iv. Muscular Dystrophy.

    c. Member is eligible to receive services from CCS for the CCS-Eligible Condition as of the day before the Member's twenty-first (21st) birthday; and

    d. Member is receiving care for the CCS-Eligible Condition from a pediatric specialist who is contracted with Health Network as of the day before the Member's twenty-first (21st) birthday.

    e. A Member who remains in Health Network pursuant to this paragraph 2 shall remain in Health Network until:

        i. The Member selects another Health Network during a subsequent Open Enrollment Period;

        ii. The Member submits a request to change Health Network For Cause in accordance with CalOptima Policy DD.2009: Member Request to Change Health Network During Lock-In Period; or

iii. The Member's pediatric specialist determines that the Member's care may safely be transitioned to another Health Network.

3. **Inapplicable Services**. To the extent that any Covered Services could not logically be provided to a Member as defined in Section 1, such as geriatrics-specialty services, Health Network shall not be required to demonstrate the capacity to provide such inapplicable services.

AMENDMENT XII TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT XII TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of _____ by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **CHOC Physician Network** ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend the Contract to include reference to pediatrics-only Health Network to better align the services it provides to CalOptima's Members.

NOW, THEREFORE, the parties agree as follows:

1. The following shall be added to the end of Article 3 "Obligations of Physician – Administrative" of the Contract:

   "3.47 Special limitations applicable to this contract regarding pediatric-only Health Network Contract exceptions are contained in Addendum II."

2. Addendum II "Pediatrics-Only Health Network Contract Exceptions" shall be added to the Contract and is attached hereto.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and **CHOC Physician Network** have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM II

Pediatrics-Only Health Network Contract Exceptions

The following terms and provisions, in addition to the terms and provisions of the Contract, shall apply to Covered Services rendered by Physician to CalOptima Members. In the event of a conflict between the terms of the Contract and the provisions set forth below, the provision set forth below shall apply:

1. **Definition of Member**. For the purposes of the Health Network, Members shall be limited to persons under 21 years of age, except for those Members who meet the criteria set forth in paragraph 2, as provided for in CalOptima policy.

    a. CalOptima shall adopt policies, procedures and practices to ensure that all Members assigned to Health Network shall meet the criteria of this section.

    b. Health Network shall notify CalOptima promptly of any Member that it believes has been assigned incorrectly to Health Network.

    c. CalOptima shall investigate, and as warranted correct, any erroneous Member assignments identified by Health Network.

2. **Membership Exception for Those 21 Years of Age and Older.** A Member shall remain in Health Network beyond the Member's twenty-first (21st) birthday if the Member meets all of the following criteria:

    a. Member does not select another Health Network;

    b. Member is diagnosed with one (1) of the following CCS-Eligible Conditions:

        i. Cystic Fibrosis;

        ii. Rare metabolic disorders, not including Phenylketonuria (PKU);

        iii. Spina Bifida; or

        iv. Muscular Dystrophy.

    c. Member is eligible to receive services from CCS for the CCS-Eligible Condition as of the day before the Member's twenty-first (21st) birthday; and

    d. Member is receiving care for the CCS-Eligible Condition from a pediatric specialist who is contracted with Health Network as of the day before the Member's twenty-first (21st) birthday.

    e. A Member who remains in Health Network pursuant to this paragraph 2 shall remain in Health Network until:

        i. The Member selects another Health Network during a subsequent Open Enrollment Period;

        ii. The Member submits a request to change Health Network For Cause in accordance with CalOptima Policy DD.2009: Member Request to Change Health Network During Lock-In Period; or

iii. The Member's pediatric specialist determines that the Member's care may safely be transitioned to another Health Network.

3. **Inapplicable Services**. To the extent that any Covered Services could not logically be provided to a Member as defined in Section 1, such as geriatrics-specialty services, Health Network shall not be required to demonstrate the capacity to provide such inapplicable services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken October 19, 2006
Special Meeting of the CalOptima Board of Directors

Report Item

IV. B. Authorize the Chief Executive Officer to Modify the Existing Contracts with Children's Hospital Orange County (CHOC) and CHOC Physicians Network (CPN) Physician Hospital Consortium (PHC) to establish a Pediatric PHC Serving Members of CalOptima's Medi-Cal and Healthy Families Programs

Contact

Gregory S. Buchert, M.D., Interim Chief Operating Officer (714) 246-8400

Recommended Action

1. Authorize the Chief Executive Officer to Modify the Existing Contracts with CHOC and CPN to establish a Pediatric PHC.

2. Authorize the Chief Executive Officer to modify certain policies and standard contractual requirements for the Pediatric PHC for the upcoming contract period, beginning January 1, 2007.

3. Authorize additional funding in FY 2006-07 of up to $1 million payable for CalOptima Health Network Medi-Cal members that access hospital services at CHOC.

Background

CHOC and CPN have participated as a PHC in the CalOptima program, as CHOC Health Alliance (CHA), since the inception of the CalOptima Program in 1995. CHA has a membership of approximately 64,000 Medi-Cal members and 14,000 Healthy Families Program (HFP) members. In an effort to ensure consistency in program development and operations at start-up, CalOptima required all PHCs to accept health network eligible members regardless of age. To respond to CalOptima requirements, CHA developed a comprehensive pediatric network and developed contractual relationships with adult providers and community and tertiary hospitals to provide health care services for adult members.

Over the last several months, CHA has conducted analysis and contract review for the proposed Medi-Cal contract effective January 1, 2007. Due primarily to changes in the marketplace and increasing financial pressures, CHOC and CPN have notified CalOptima verbally that neither would renew their Medi-Cal contracts with CalOptima.

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To continue to serve CalOptima members, CHOC and CPN have requested that its current PHC be modified to limit membership to pediatric members. The members currently enrolled in CHA who are aged 21 and under and those members with a qualifying chronic CCS eligible condition that remain under the care of pediatric specialists will continue enrollment in the Pediatric PHC. As new members (both Medi-Cal and Healthy Families) become eligible for the CalOptima Program they will be able to choose to enroll in the Pediatric PHC based upon the Pediatric PHC enrollment criteria. This will allow CHOC and CPN to continue serving children in the CalOptima program as a participating PHC.

CPN is in active discussions regarding the continued provision of Covered Services for the members currently enrolled with CHA Health Network, but who will not meet the enrollment criteria for the Pediatric PHC. Staff has informed CPN that a proposal must be received by October 19, 2006. If a proposal is not received the adult Medi-Cal and Healthy Families members will be transitioned in accordance with CalOptima's Transition and Special Open Enrollment policies.

Based on staff analysis, approximately 19% (12,487) of the current CHA members are older than 21 years of age. Roughly 61% of all of the CHA physicians have an affiliation with one or more other Health Networks. Of those physicians without another health network affiliation, there is the potential for approximately 3,000 adult members having their care disrupted if their PCPs do not affiliate with another Health Network medical group.

Discussion

The CalOptima Board of Directors is responsible for arranging for the provision of health care services to individuals and families who are enrolled in the CalOptima program and has, per policy, the authority to contract with providers of services in order to ensure adequate access to provide covered services.

To review the 2007 Medi-Cal Health Network Contract for Health Care Services issues facing CalOptima, an Ad Hoc Committee of the Board of Directors was created. After reviewing these issues, the Ad Hoc Committee recommended that CalOptima allow the creation of a Pediatric PHC to focus on a pediatric population. The Ad Hoc recognizes CHOC's important role in providing health care services to the children of Orange County and also recognizes the development of a Pediatric PHC in supporting the participation of CHOC and pediatric providers.

In conjunction with the implementation of a Pediatric PHC, staff recommends that several contract items and policies be revised to recognize unique features of this arrangement to ensure that a Pediatric PHC enjoys relatively stable enrollment.

Health Networks are usually not in the position of having all members being required to universally select a different health network when they reach age 21. Additionally, health network membership is typically augmented by babies being born to pregnant member mothers, family linked members and auto-assignment. While all other health networks' membership levels will benefit from these activities, a situation may be set up that results in diminishing membership in the Pediatric PHC. CHOC's initial proposal and other discussions covered various approaches to addressing these issues. To address these concerns, the recommended approach is to amend two CalOptima policies. Should the Pediatric PHC's enrollment begin to fluctuate significantly, it is anticipated that these changes, if implemented, would be revisited.

1. Recent changes in the Family Link process allows parents or guardians to one or more health networks to best meet their families needs, including choosing a Pediatric PHC for their children if desired. Staff recommends an additional change to family link methodology that allows siblings in a family to stay together. If a child is a member in one PHC (Regular or Pediatric), and a sibling is eligible to become a new member; that sibling would be linked to the health network of his/her sibling even if the parent/guardian were in another PHC. The parent/guardian would retain the opportunity to choose a different network according to CalOptima policies.

2. Of children under 6 months of age who gain eligibility, approximately 73% have a family member with a network affiliation and will continue to be family linked to that network. For the remaining 23%, the parent/guardian will be asked to choose a health network. If a network is not chosen, it is recommended that these infants be assigned directly to the Pediatric PHC rather than being auto-assigned.

With the 2007 Medi-Cal contract, CalOptima currently requires a health network to document access to healthcare services (hospitals and physicians) appropriate for members of all ages. Staff recommends that the Pediatric PHC be required to document access to healthcare services necessary to treat a pediatric population.

To ensure CalOptima members in health networks have access to CHOC when appropriate, it is recommended that CalOptima, on a quarterly basis, provide

reimbursement for the difference between the CHOC hospital blended per diem rate and the CMAC-like per diem rate of the next highest COD-contracted hospital. Total additional payments for all Health Network members shall not exceed $1 million during fiscal year 2006-2007.

Fiscal Impact

Additional annual expenditures will be paid for Health Network members when these CalOptima members are placed in CHOC by their Health Networks. This amount is unbudgeted, and will have a $1 million impact on the FY 2006-07 budget.

Rationale for Recommendation

The CalOptima delivery system should be capable of evolving as necessary to best meet the needs of its membership. The development of a Pediatric PHC will ensure the best outcome and access for continued and consistent care for the pediatric population served by CHA. While taking such action does require CalOptima to develop an alternate PHC model, by doing so, the approach will provide for consistency in the PHC's ability to provide for services for which it accepts risk.

Concurrence

Foley & Lardner LLP

Attachments

None

Richard Chamberlain — **Authorized Signature**

10/17/06 — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

23. Authorize New and Amended Contracts for ARTA Western California Inc., Monarch HealthCare A Medical Group Inc., and Talbert Medical Group P.C. to Reflect Name Changes

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Authorize the Chief Executive Officer, to execute:

1. New Shared-Risk Group (SRG) Medi-Cal and OneCare Connect health network contracts for ARTA Western California Inc. and Talbert Medical Group P.C. to reflect a name change to ARTA Western California Inc. dba Optum, and Talbert Medical Group P.C. dba Optum, to be effective March 1, 2022, and
2. Amendments to the OneCare Shared-Risk Group (SRG) contracts for ARTA Western California Inc., Monarch HealthCare, A Medical Group Inc. and Talbert Medical Group P.C. contracts, to reflect a name change to ARTA Western California Inc. dba Optum, Monarch HealthCare, A Medical Group Inc. dba Optum, and Talbert Medical Group P.C. dba Optum, to be effective March 1, 2022

Background & Discussion

Staff requests authority to execute new and amended contracts with ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., and Talbert Medical Group P.C. to reflect name changes for the networks, as follows:

Original Name	Updated Name
ARTA Western California Inc.	ARTA Western California Inc. dba Optum
Monarch HealthCare, A Medical Group Inc.	Monarch HealthCare, A Medical Group Inc. dba Optum
Talbert Medical Group P.C.	Talbert Medical Group P.C. dba Optum

The contracts and amendments contain no other changes in terms and obligations, other than a provision recognizing that combined enrollment in health networks that share ownership will not exceed the membership concentration limit under CalOptima Policy.

Staff requests authority to enter into these new contracts and amendments, effective March 1, 2022, to reflect the updated health network names.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

Authorizing these amendments will reflect the wishes of its Medi-Cal, OneCare, and OneCare Connect partners, and allow for continuity of its relationship with ARTA, Talbert, and Monarch.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Proposed New Contract for ARTA
3. Proposed New Contract for Talbert
4. Proposed Contract Amendment for ARTA
5. Proposed Contract Amendment for Monarch
6. Proposed Contract Amendment for Talbert

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245

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MEDI-CAL

PHYSICIAN – SHARED RISK

AMENDED AND RESTATED

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

ARTA WESTERN CALIFORNIA, INC. DBA OPTUM

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AMENDED AND RESTATED
CONTRACT FOR HEALTH CARE SERVICES

PHYSICIAN
(Shared Risk)

THIS CONTRACT FOR HEALTH CARE SERVICES ("Contract") is entered by and between Orange County Health Authority, a public agency, dba CalOptima, ("CalOptima"), and **ARTA Western California, Inc. dba Optum,** ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. Physician is a California professional medical corporation, which employs or otherwise contracts with physicians who are physicians licensed to practice medicine in the State of California.

D. Physician desires to provide or arrange for the provision of Covered Services to Members as defined herein.

E. CalOptima and Physician desire to enter into this Contract on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the Physician and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal

Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 "Advance Directive" means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 "Aid Code" means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 "American Indian" means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 "American Indian Health Care Provider" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.7 "American Indian Health Service Programs" means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000.

1.8 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

1.9 "California Children's Services (CCS)" means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or Physician group.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Physician, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designee, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the Physician by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by Physician's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi-Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or Physician group or from one Health Network or Physician group to another Health Network or Physician group; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq., that covers certain pediatric preventive services for children eligible for Medi-Cal. .

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 "Community Liaison" or "CL" means an individual designated to perform the duties set forth in this Contract and CalOptima Policies, as part of the Community Liaison Program.

1.23 "Community Liaison Program" or "CLP" means a program created and operated by CalOptima to facilitate access to Covered Services and coordination of care for SPD Members enrolled in a Health Network or Physician group.

1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes basic case management.

1.25 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and Physician. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on Physician, DHCS Medi-Cal Managed Care Policy Division Policy Letters.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22, of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network or Physician group regardless of Health Network or Physician group reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the Hospital for purposes related to this Contract; or
1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the Hospital(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their

children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act").

1.45 "Health Network" means a physician hospital consortium (PHC), physician group under a shared risk contract, or health care service plan, such as an HMO, as defined

in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act) and having a Hospital Services Contract with CalOptima.

1.49 "Incontinence Supplies" means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 "Joint Commission" means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 "Management Services Organization" or "MSO" means any organization, firm, company or entity providing Administrative Services on behalf of Physician which impact CalOptima Members.

1.53 "Medi-Cal" is the name for the Medicaid program in the State of California, and "Medicaid" is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 "Medi-Cal Fee Schedule" means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedure at the Federal or State levels. The Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When

determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v).

1.57 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 "Medical Screening Examination" or "MSE" means an examination within Physician's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD)) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and assigned to Physician.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU" means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks, Physician groups and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled with Physician.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with Physician or Hospital to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of Physician. All Participating Providers shall be considered Subcontractors.

1.71 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 "Pediatric Preventive Services" or "PPS" means well child services which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.76 "Physician" means a group practice, independent practice association or other formal business arrangement comprised of individuals, each of whom hold an unrestricted license to practice medicine or osteopathy in the state in which they practice, and which participates with a Hospital in a PHC or holds a shared risk contract with CalOptima.

1.77 "Physician Incentive Plan" means any compensation arrangement between Physician and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.78 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 "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.

1.80 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.81 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.82 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.83 "Reinsurance" means coverage provided by CalOptima and any coverage secured by Physician, which limits the amount of risk or liability for the cost of providing Covered Services.

1.84 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a primary care physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

1.85 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing

1.86 "Shared Risk Pool" means the risk sharing program, described in Attachment E hereto, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and Physician.

1.87 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes.

1.88 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.89 "Specialized Durable Medical Equipment" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.90 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.91 "Specialty Mental Health Services" means:

1.91.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.91.2 Psychiatric inpatient hospital services;

1.91.3 Targeted Care Management services;

1.91.4 Psychiatrist services;

1.91.5 Psychologist services; and

1.91.6 EPSDT supplemental specialty mental health services.

1.92 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.93 "State" means the State of California.

1.94 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.95 "Subcontract" means an agreement entered into by the Physician with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract.

1.96 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Physician. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates.

1.97 "Sub-delegation" means the process by which Physician expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by Physician in order to meet its obligations under, and the intent of this Contract.

1.98 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, APL 17-011, or any update or revision thereof.

1.99 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.100 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.101 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
Obligations of Physician – Financial

2.1 FINANCIAL SECURITY REQUIREMENTS --- Physician must establish and maintain, throughout the term of this Contract, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, equal to fifty-thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one month's Capitation Payment.

Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit.

2.2 INDEMNIFICATION --- Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

2.3 INSURANCE REQUIREMENTS---

2.3.1 Professional/Medical Malpractice:

Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician :
$1,000,000 per incident/$3,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:

Physician and each Participating Provider shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate

Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:

Physician and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:

$1,000,000 Bodily Injury by Accident - each accident

$1,000,000 Bodily Injury by Disease - policy limit

$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:

Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:

$10,000,000 each claim/$10,000,000 aggregate

2.3.5 Insurer Ratings ---
Such insurance shall be provided by an insurer:

(a) rated by A.M. Best with a rating of A V or better; and

(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

2.3.6 Captive Risk Retention Group/Self Insured:

Where any of the Insurance(s) mentioned in this Section are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.7 Cancellation or Material Change:
The Shared Risk Group shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.8 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT --- Physician shall reimburse the Local Health Department (LHD) on a FFS basis, according to the current Medi-Cal Fee Schedule, for certain Covered Services provided to Members, in accordance with

CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 PHYSICIAN FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- Physician shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 AS SET FORTH IN ATTACHMENT A, the Division of Financial Responsibilities, Physician shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment with the exception of certain Medical Supplies as set forth in Attachment C.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.6 Not Applicable to this Contract.

2.7 PHYSICIAN PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - Physician and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

2.7.2 Claims Turnaround Time - Physician shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician, unless the claim or portion thereof is reasonably contested by Physician, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician in accordance with CalOptima Policy.

2.7.3 Claims Adjudication – Except as provided in this Section, Physician shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.7.4 Dispute Resolution - Physician shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider

disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - Physician shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of Physician

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If Physician does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that Physician fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from Physician for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that Physician fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from Physician for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce Physician Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of Physician, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

2.7.8.1 Physician shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Physician's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 Physician shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of Physician, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 Physician's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 Physician shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the physician group. Physician will receive misdirected claims per CalOptima Policy.

2.7.9.2 Physician shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of

the claim. CalOptima shall receive these files per CalOptima Policy and load them into their system to ensure timely claims processing.

2.7.10 FQHC Payments – If FQHC, Physician shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services.

2.7.11 American Indian Health Service Payments - Physician shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. Physician shall reimburse the American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in Physician's provider network, Physician shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy.

2.7.13 Family Planning Provider Payments - Physician shall reimburse non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy. Physician shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.7.14 Sexually Transmitted Disease Treatment Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Physician may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Physician along with billing information.

2.7.15 HIV Testing and Counseling Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy. Physician shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Physician.

2.7.16 Information Disclosures To Participating Providers Physician shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon

request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments –

2.7.17.1 Physician shall reimburse contracted Specialist Physician for Covered Services rendered to Members on an aggregate basis, at an amount equal to or greater than one hundred thirty-three percent (133%) of the Medi-Cal fee schedule except for those members specified below.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by Physician and the physician and surgeon.

2.7.18 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- Physician shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- Physician shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by Physician and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall Physician cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased Members. Physician shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. Physician shall not undertake cost avoidance or post-payment recovery except on

the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS; or in child support enforcement cases. If Physician does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then Physician shall follow the procedure above for cost avoidance. If Physician does not reimburse a Provider on a Fee-for-Service basis, then Physician shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 Physician shall have written policies implementing these requirements.

2.9.4 Physician shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 Physician shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 Physician shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 Physician shall demonstrate to CalOptima that where Physician does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Physician projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- Physician shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%) when combined with the revenues and expenses of the Shared Risk Pool, which are identified in Attachment E.

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- Physician shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. Physician shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care that are required under Section 1300.75.4.2 of Title 28 of the California Code of Regulations.

2.12 COOPERATION WITH DMHC --- Physician shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to Physician, in accordance with Section 1300.75.4.7 of Title 28 of the California Code of Regulations. Physician shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process, in accordance with Section 1300.75.4.8 of Title 28 of the California Code of Regulations.

2.13 Not Applicable to this Contract.

ARTICLE 3
Obligations of Physician - Administrative

3.1 Not Applicable to this Contract.

3.2 EQUAL OPPORTUNITY

3.2.1 Physician 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. Physician and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Physician and its Subcontractors' obligation

under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

3.2.2 Physician and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Physician and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.2.3 Physician and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Physician and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 Physician and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.2.5 Physician and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.2.6 In the event of Physician and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician and its

Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.2.7 Physician and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Physician and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Physician and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Physician and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- Physician shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- Physician shall display the CalOptima logo on all Physicians' written communication to Members pursuant to CalOptima Policies, and in a manner such that it is clear to the Member that the communication is referring to the CalOptima program. Physician shall not otherwise use CalOptima's logo for any business unrelated to this Contract.

3.5 MEMBER INQUIRIES AND CALLS --- Physician shall establish and maintain a call center for receiving and responding to Member inquiries and calls. Physician's call center shall meet requirements established by CalOptima Policies. Physician shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure Physician will be able to supply call center reports as required by CalOptima Policies.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, Physician shall ensure that all written Member information provided by Physician to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. Physician shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by a Physician. Physician shall implement and comply with CalOptima Policies relating to Member grievances. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by Physician. Physician shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES.

Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, Physician may sub-delegate to an MSO, medical group, and/or IPA administrative functions required of Physician but shall not absolve Physician of oversight responsibilities. All sub-delegation must be approved by CalOptima. Physician shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. Physician's sub-delegation to another entity does not alter Physician's ultimate obligation and responsibilities set forth in this Contract. Physician may give a sub-delegate the authority to act on behalf of Physician; but Physician retains oversight and accountability for the sub-delegated function. Accountability means that Physician cannot abdicate responsibility for the function being performed according to the requirements of this Contract, Physician's standards and those established by this Contract and CalOptima Policies. Physician is accountable for all functions performed in its purview whether by Physician, by any sub-delegate or by any sub-sub-delegate. If Physician chooses to sub-delegate a function, Physician must demonstrate that it has not compromised its ability to evaluate

structures and processes and to achieve required performance across its Membership and provider network. At a minimum, Physician shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the Provider and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the Physician and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the Physician evaluates the sub-delegate entity's performance; and

3.8.1.5 The Physician's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the Physician's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the Physician's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The Physician's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The Physician's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 Physician shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 Physician shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of Physician's Members, including those receiving services from a sub-delegate of Physician.

3.8.6 Physician shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve (12) month period. Physician shall establish standards and performance requirements for the sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of Physician in this Contract and in CalOptima Policies. Physician may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network or Physician group, or as a participant in a Health Network (i.e. a Shared Risk Group, PHC Physician Group or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by Physician to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. Physician shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. Physician shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- Physician may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Physician is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Physician is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. All subcontracting with an offshore entity must be approved by CalOptima prior to execution of the Subcontract. Additionally, Physician shall require all Subcontracts that relate to the provision of Covered Services, include the following:

3.9.1 An agreement to make all premises, facilities, equipment, books records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Sections 3.17 to 3.22 of this Contract;.

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10 and 7.11 of this Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or Physician, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on Physician;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services, and State Contract (Exhibit A, Attachment 8, Provision 13) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify Physician of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; and (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, as set forth in Attachment D of this Contract, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event Physician cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with Physician and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract.

3.9.15 In the event that Physician implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by Physician.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Physician delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract (including the Delegation Acknowledgement and Acceptance Agreement);

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or

Physician determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the Physician to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Subcontractors are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program.

3.10 PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- Physician shall comply with the following organization and operations structure requirements:

3.10.1 Single Board of Directors and management team.

3.10.2 Medical Director/CMO providing full time coverage. Duties shall include:

- Ensuring that medical decision are:
  - Rendered by qualified medical personnel
  - Are not unduly influenced by fiscal or administrative management considerations.
- Ensuring that the medical care provided meets the standards for acceptable medical care.
- Ensuring that medical protocols and Standards of Conduct for medical personnel are followed.
- Developing and implementing medical policy.
- Resolve grievances related to medical quality of care.
- Have a role in the implementation of Quality Improvement activities.
- Actively participate in the functioning of the grievance procedures.

- Actively participate in Quality activities including Credentialing and Peer Review.

- Acts as liaison and participates with CalOptima in any activities related to Medical Director/CMO duties.

PHYSICIAN shall report to CalOptima any changes in the status of its Medical Director within ten (10) calendar days.

3.10.3 No employee of Physician, including but not limited to Medical Director(s) and/or the Chief Medical Officer, that make decisions regarding the authorization and/or provision of Covered Services to Members shall have a financial incentive or otherwise benefit financially from decisions made regarding authorization and/or provision of Covered Services to Members, nor shall such an employee have any fiscal or administrative duties or responsibilities that may unduly influence medical judgments.

3.10.4 Single Credentialing Committee and credentialing policies, procedures and standards.

3.10.5 Single and unified health care delivery system including but not limited to:

3.10.5.1 Participating Providers must be accessible to all members enrolled with Physician.

3.10.5.2 Members can select any contracted PCP with an open panel.

3.10.5.3 A PCP can refer members to any contracted specialist.

3.10.5.4 Physician must report to CalOptima all required data for the total enrollment of the Physician and the total provider network regardless of sub-delegation or other contractual relationships including but not limited to; complaints, encounter data, utilization management data, financial reports, PCP changes and PCP assignments.

3.10.5.5 Centralized call center receiving all member and provider calls.

3.10.5.6 Single access number to call center.

3.10.5.7 Standard member communication for all members.

3.10.6 Other organization and operations structure requirements as may be established and modified from time to time by CalOptima.

3.11 ENROLLMENT --- Physician shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to Physician.

3.12 PCP ASSIGNMENT --- Physician shall assign Members who have been automatically assigned to Physician by CalOptima to a PCP within seven (7) days of the Member's assignment to Physician.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE ---Physician shall mail to a Member or Member's head of household a notice of enrollment and a Physician Member handbook or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with Physician. All member handbooks and supplements prepared by Physician shall be submitted to CalOptima for approval prior to printing. Physician shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should Physician choose to utilize the CalOptima Member handbook, Physician-specific information on each topic as defined by CalOptima Policies must be included in a CalOptima approved supplement to the CalOptima Member handbook given to all Physicians' CalOptima Members. CalOptima shall provide Physician with a template for the supplement to the CalOptima member handbook.

3.13.2 If Physician chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, Physician's Member handbook shall contain all information included in the CalOptima Member handbook and Physician-specific information on each topic as defined by CalOptima Policies.

3.13.3 Physician shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. Physician shall also provide one (1) copy of its enrollment information including its Physician Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- Physician may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from Physician. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- Physician shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- Physician shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a

historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with CCR Title 22, Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Physician shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

3.17.1 Physician and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. Physician shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services in accordance with CalOptima Policies.

3.17.3 It is understood that all Physician, Subcontractors', and Participating Providers' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at Physician, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the Physician, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- Physician and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law, with the exception in which the Physician or Subcontractor has been duly notified that DHCS, DHHS, the Department of

Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 Physician shall upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18 without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any monitoring, inspection or evaluation is made of the premises of Physician or Subcontractor, Physician shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, Physician shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the Physician's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, Physician shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and

audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by Physician and Subcontractors pertaining to these services at any time,, pursuant to 42 CFR section 438.3(h). Records and documents include but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, Physician shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at Physician's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Physician's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of Physician's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Physician, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to Physician. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and Physician will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Physician and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS. Throughout the duration of the Contract and the retention period specified in Section 3.18, Physician and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to Physician's provision of and reimbursement for activities contemplated under the Contract, and to Physician's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign Physician's statement of confidentiality prior to being admitted access to Physician's premises. This provision shall survive the

expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Physician at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Physician from participation in the Medi-Cal program; seek recovery of payments made to the Physician; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, Physician 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 Physician's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Physician asserts that any requested documents are covered by a privilege, Physician shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Physician acknowledges that time may be of the essence in responding to such request. Physician shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Physician or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 Physician further agrees to timely gather, preserve, and provide to DHCS any records in the Physician's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- Physician and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- As identified in Attachment B, Physician shall keep CalOptima informed as to the names of the officers and owners of Physician holding more than five percent (5%) of the stock issued by Physician,

and major creditors holding more than five percent (5%) of the debt of Physician and shall notify CalOptima whenever changes occur to the information provided therein.

3.23.1 If provider is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Physician shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

3.24 FRAUD AND ABUSE REPORTING --- Physician shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out of Network Providers, Members, or Physician's employees, within two (2) working days of the date when Physician first becomes aware of or is on notice of such activity.

3.24.1 Physician shall notify CalOptima, and CalOptima shall notify DHCS prior to Physician conducting any investigations. Physician shall conduct an investigation after notification has been given.

3.24.2 Physician shall establish, for approval by CalOptima and DHCS, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 Physician shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- Physician shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Physician's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 PHYSICIAN COMPLIANCE PROGRAM --- Physician shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the Physician annually to ensure that it remains effective. Physician shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM --- Physician and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Physician's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to Physician and Physician shall make them available to Physician's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Physician shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Physician's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and State and/or federal regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- Physician agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. Physician acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOUs) --- Physician agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS --- Physician shall have policies and procedures to verify the Participation Status of Physician's Agents. Physician shall refer to the Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, Physician warrants and agrees as follows:

3.31.1 Physician and Physician's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 Physician shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by Physician or Physician's Agents occurring and/or discovered during the term of this Contract.

3.31.3 Physician shall take immediate action to remove any Physician Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 Physician shall include the obligations of this Section in its Subcontracts.

3.31.5 CalOptima and Physician, as applicable, shall not make payment for a health care item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Physician shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither Physician nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Physician and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 Physician and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age,

sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 Physician shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 Physician shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 Physician shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. Physician shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 Physician shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate

services. Physician shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. Physician shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. Physician shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, Physician shall provide translation of written member informing materials in the Threshold and Concentration Languages. Physician shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, Physician shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. Physician shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. Physician shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- Physician shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by Physician or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. Physician shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. Physician shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, Physician shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, Physician must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. Physician shall routinely document the language needs of Members and the request or refusal of interpreter services in

a Member's medical record. This documentation shall be available to CalOptima at CalOptima's request. Physician shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. Physician shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- Physician shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. Physician shall make Member Rights available to Member..

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- Physician shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 Physician and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 Physician shall comply with HIPAA requirements as currently established in CalOptima Policies. Physician shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the Physician HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 Physician and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to Physician, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Physician's obligations under this Contract. Physician and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Physician shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Physician from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Physician is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Physician or its Subcontractors, Physician:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Physician by DHCS for this purpose.

3.39 REINSURANCE -- CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance. Physician may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, Physician shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.39.3 In lieu of CalOptima-provided reinsurance, services for CCS Members shall be subject to interim reimbursement for catastrophic cases and retrospective risk corridors, as provided in Attachment E of this Contract.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- Physician shall have a process for claims management and administration. Physician shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. Physician shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE --- Physician shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all CalOptima Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the Physician being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received a MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. Physician shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- Physician acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Physician shall perform all such obligations and duties.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- Physician shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. Physician shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of Physician's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- Physician shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 PHYSICIAN SUBCONTRACTS --- In addition to Section 3.9 of this Contract, Physician shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. Physician shall ensure that all Subcontracts are in writing and require that the Physician and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the final date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – Physician understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of Physician under this Contract. In instances where DHCS or CalOptima determines that the Physician or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations to the Physician, (b) require the Physician to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. Physician shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of Physician or the oversight of those obligations.

3.47 Physician acknowledges and agrees that member enrollment combined across Health Networks sharing the same Officer(s), Director(s), General Partner(s) and/or Co-Owner(s), as specified in Attachment B (Disclosure Form) of the Contract, shall not exceed one-third (1/3) of all Members eligible for Health Network enrollment.

ARTICLE 4
Obligations of Physician – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- Physician shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of Physician, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that Physician is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, Physician shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. Physician shall provide Covered Services to Members and Physician agrees as follows:

4.1.1 Physician shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered

Services to Members that are the financial responsibility of Physician as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If Physician's network is unable to provide necessary medical services covered under this Contract to a particular Member, Physician must adequately and timely cover these services out of network for the Member, for as long as Physician is unable to provide them. Physician shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 Physician shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating with Physician as to the Medical Necessity of the service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 Physician shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the Physician denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. Physician acknowledges that disputes between the respective Physician and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 Physician may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Physician may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 Physician shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by

CalOptima or Physician, CalOptima's or the Physician's insolvency, or breach of this Contract by the Physician or CalOptima, shall Physician or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit Physician or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. Physician or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services, and a copy of such agreement is given to the Member and placed in the Member's Medical Record. Physician further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Physician and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the Physician's Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the Physician and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 That, in the event of a violation of this Section by Physician or Subcontractor, including, but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against Physician or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- Physician shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 13). Physician is required to provide and pay for all Emergency Services, including Emergency Services provided by Out of Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 Physician shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if Physician reasonably determines that Emergency Services were never performed.

4.2.2 Not Applicable to this Contract.

4.2.3 Physician shall reimburse those physicians providing services in an Emergency Department with whom Physician has a contract according to the terms of that contract. Physician shall offer to enter into a contract with any physician group contracting with CalOptima for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that CalOptima contract. Physician shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 Physician shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. Physician shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, Physician shall not deny payment for treatment obtained when Physician or a Participating Provider instructs the Member to seek Emergency Services.

4.2.6 Physician shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between Physician or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. Physician may establish relationships with treating facility whereby the Physician may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently

Stabilized for transfer or discharge and that determination is binding on Physician.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Physician is financially responsible for post-stabilization services obtained within or outside Physician's network that are pre-approved by a plan provider or other entity representative. Physician is financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other Physician representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to Physician for pre-approval of further post-stabilization care services.

4.2.8.1 Physician is also financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if Physician does not respond to a request for pre-approval within 30 minutes; Physician cannot be contacted; or Physician's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, Physician must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 Physician's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Not Applicable to this Contract.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, Physician is financially responsible for payment for post-stabilization services following an emergency admission. Physician shall reimburse those physicians providing post-stabilization services with whom Physician has a contract according to the terms of that contract. Physician shall reimburse all non-contracted physicians providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

4.3 NEWBORN SERVICES --- Physician shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- Physician is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Physician shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. Physician's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services, shall not be required.

4.4.1 Physician shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires Physician to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out of Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve Physician from financial responsibility for such services.

4.4.2 Physician shall not prevent Members from receiving Family Planning Covered Services from Out of Network Providers.

4.4.3 Physician shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. Physician shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 Physician shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the Physician has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 Physician shall incorporate specifications of this Section in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- Physician shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH PHYSICIAN OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, Physician shall

arrange for the timely referral and coordination of Covered Services to which Physician or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

4.7 ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES. Physician shall ensure the provision of SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network Physician without first requesting a referral from a network Primary Care Physician. Physician shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within Physician's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM --- Physician acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and meeting DHCS access and other requirements. Upon meeting those conditions, CalOptima shall notify Physician of the date upon which Physician will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time Physician shall commence all CalOptima WCM obligations.

ARTICLE 5
Obligations of Physician – Access

5.1 TWENTY-FOUR (24) HOUR PHYSICIAN COVERAGE ---- Physician shall ensure that a physician Participating Provider or physician employed by Physician is available twenty-four (24) hours a day, seven (7) days a week for timely authorization and consultation for Medically Necessary Covered Services, including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, Physician shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies

5.2 URGENT CARE SERVICES --- Physician shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- Physician shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with

CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Physician shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Physician's failure to perform at or in excess of minimum performance requirements shall subject Physician to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- Physician shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.5 Not Applicable to this Contract.

5.6 DAYS TO APPOINTMENT---

5.6.1 Non-Emergency Covered Services – Physician shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. Physician shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – Physician shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. Physician shall arrange for the provision of specialty services from specialists outside the network if unavailable within Physician's network, when determined medically necessary.

5.6.3 Preventive Covered Services – Physician shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the

treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services – Physician shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. Physician shall cover and ensure the provision of all Medically Necessary services for pregnant Members. Physician shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement – Physician shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
5.6.7.2 Urgent appointment for services that do require prior authorization – within 96 hours of a request;
5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;
5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician for any reason, Physician shall ensure that there is no disruption in services provided to members who are receiving treatment for a chronic or ongoing medical condition or LTSS.

5.7 OFFICE WAITING TIMES --- Physician shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. Physician's failure to monitor and enforce Participating Provider

office wait time requirements in accordance with the terms of this Contract may subject Physician to sanctions as set forth in this Contract and CalOptima Policies.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- Physician shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialty Physician referrals as set forth in CalOptima's utilization management program. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Physician's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. Physician's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

5.10 NOTICES ABOUT PCP CHANGES --- Physician shall give Members thirty (30) calendar days' notice if their PCP withdraws from Physician. All notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by Physician. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within the Physician for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- Physician shall offer each Member the opportunity to choose a PCP affiliated with the Physician. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When Physician receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, Physician shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment with Physician. Physician shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12 PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, Physician shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, Physician shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1 Primary Care Physicians 1:2,000 Members;
5.13.1.2 Total physicians 1:1,200 Members; and
5.13.1.3 If Non-Physician Medical Practitioners are included in Physician's Network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

5.13.2 Supervising Physicians - Physician shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or
5.13.2.2 Four (4) physician assistants; or
5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- Physician shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- Physician shall make available to every Member, Specialists whose offices are located within fifteen (15) miles or thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). Physician shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles from Member's place of residence.

5.16 PHYSICAL ACCESS --- Physician's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.17 ACCURACY OF PROVIDER DIRECTORY --- Physician shall notify CalOptima within five (5) business days when either of the following occur:

5.17.1 The Provider is not accepting new Members.

5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members.

ARTICLE 6
Obligations of Physician – Clinical Quality

6.1 LICENSURE --- Physician shall ensure that every physician providing Covered Services and employed or engaged by Physician or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- Physician shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;
6.2.2 Refer Members to appropriate HEP, based on the Member's needs;
6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,
6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- Physician shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide

only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- Physician shall participate and cooperate in CalOptima's Quality Improvement Program. Physician shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, as well as a semi-annual report to CalOptima's QI department using the Industry Collaboration Effort (ICE) Reporting Tool, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. Physician shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). Physician shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of the Physician or a multi-disciplinary QI Committee designated by the Board of Directors of Physician shall oversee the QI Program conducted by Physician. This committee shall be separate from the Utilization Review committee (though members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from Physician. The QI Committee shall meet at least on a quarterly basis. Physician shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to Physician's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

6.4.6 Physician's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 Physician shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or Physician; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 Physician shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the Physician's QI Program shall be established by the Physician's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify Physician of any additional changes in QI standards and requirements that shall be incorporated in Physician's QI Program. Physician shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 Physician shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, Physician shall provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 Physician shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 Physician shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- Physician shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 Physician shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 Physician Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care, concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review Physician's Case Management Services program to determine compliance with Case Management Services standards. Physician shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 Physician Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, Physician shall assure that Physician possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 OBLIGATION OF PHYSICIAN UPON TERMINATION OF CONTRACTED PROVIDERS --- Physician shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site, and assisting them in selecting a new PCP or PCP site. Physician shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date, and assist them in selecting a new PCP or PCP site. Physician shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. Physician shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or Physician decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with Physician, but the rest of the group continues its contract with Physician, then Physician shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2nd) or third (3rd) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019 or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for

Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, Physician shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by Physician's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Physician shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- Physician shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment. Physician shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. Physician's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions to treat a CCS Eligible Condition. However, Members cannot be limited to a single delegated entity's provider network. Physician must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, Physician may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated Physician shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated Physician shall implement procedures to identify individuals who may need

or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- Physician shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, Physician shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 Physician shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, Physician shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 Physician shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by Physician, Physician remains

responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code, Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), Physician must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, Physician may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, Physician must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Physician's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Physician and the CCS Provider.

6.7.5.2.3 Physician confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or the Provider of Specialized Durable Medical Equipment makes treatment information available to Physician, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, Physician and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, Physician shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Physician shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. Physician shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 Physician shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, Physician shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 Physician shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, Physician shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for

Members receiving continuity of care, Physician shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition Physician for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if Physician denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 Physician must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 CREDENTIALING REQUIREMENTS --- Physician acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to Physician. Physician shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

6.8.1 Physician shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 Physician shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. Physician shall ensure that any Participating Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 Physician shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 Not Applicable to this Contract.

6.9 BOARD CERTIFICATION --- --- Physician shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 Physician shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or

services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 Physician acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations (IPA) and/or other organization or entity that contracts with Physician to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW (FSR/MRR) --- Physician shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. Physician shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- Physician shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 Physician shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the Physician.

6.11.4 Physician shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 Physician shall be responsible for coordinating care of certain services including:

6.11.8.1 Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 Physician shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 Physician shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 Physician shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 Physician shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 Physician shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. Physician shall develop referral and prior authorization policies and procedures to implement the above requirements. Physician shall submit these policies to CalOptima for review and approval;

6.11.8.9 Physician shall provide outpatient mental health services within the PCP's scope of practice. Physician shall refer Members requiring inpatient mental health services to the Orange County Health Care Agency (HCA) Behavioral Health Services. Physician shall retain financial responsibility for initial physical health assessment for any Member admitted to an inpatient

facility. This assessment shall be performed by a facility physician or by the Member's PCP. Physician shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services.

6.11.8.10 Mental Health Services. Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall retain financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU.;

6.11.8.11 For Outpatient Mental Health Services , Physician shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP's scope of practice, Physician shall refer Members to CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, Physician shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

6.11.8.12.1 Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain

financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 Physician shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the Physician is responsible for the coordination of care for Members, CalOptima shall share with Physician, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and Physician shall receive the utilization data provided by CalOptima and use it as the Physician is able for the purpose of Member care coordination.

6.12 VACCINES --- Physicians shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with Physician's immunization policy. CalOptima shall not reimburse Physician for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the CalOptima Approved Drug List and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by CalOptima. The prescribing physician shall be responsible for submitting prior authorization requests and responding to requests for additional information in accordance with regulatory timeframes. The prescribing physician shall provide CalOptima all information necessary to process prior authorization requests.

6.13.1 Physician may be subject to sanctions for Participating Provider's failure to comply with the prior authorization process.

6.13.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.14 RESEARCH --- Physician agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF PHYSICIAN FOR SPD --- Physician shall provide the following for SPD Members:

6.15.1 Physician shall participate in the Community Liaison Program according to the guidelines and policies CalOptima promulgates to operate the program and as set forth in this Contract and CalOptima Policies;

6.15.2 Physician shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 Physician shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. Physician shall not restrict the Incontinence Supplies by brand name as long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 Physician shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) Physician determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD Member's need for the Medical Supplies will remain stable over the six (6) month period.

6.15.5 Physician or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. Physician shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, Physician shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the Physician;

6.15.6 Physician shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. Physician shall provide to all SPD Members upon enrollment with Physician and at any time thereafter, upon the SPD Member's request, a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment with Physician of an SPD Member, Physician shall complete a plan of care pursuant to

CalOptima Policies. Physician shall update this plan as appropriate and/or annually. Physician shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies enrolled with Physician, Physician shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 Physician shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 Physician shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

6.15.11 If Physician's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, Physician must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. Physician acknowledges that out-of-network providers must coordinate with Physician with respect to payment, and Physician shall ensure that such out-of-network providers understand this requirement. Physician must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. Physician shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member, in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, Physician shall provide continued access for up to twelve (12) months to an out-of-network provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom they are receiving services), if the provider will accept Physician or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an out-of-network provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, Physician shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and

linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 Physician and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS.

6.15.14 Personal Care Coordinator (PCC) Programs for CCS and SPD Members Definitions:

6.15.14.1 "Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members. The Profile shall include the compliance parameters required to receive PCC supplemental capitation.

6.15.14.2 "Individual Care Plan" is a plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

6.15.14.3 "Personal Care Coordinator or PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an CCS Eligible Condition as determined by the local CCS Program, or SPD aid code, supervised by a licensed person, and funded by CalOptima.

6.15.15 Physician shall be eligible to receive the supplemental PCC capitation as defined in Attachment E if Physician remains in good standing with CalOptima which shall include but not limited to the following:

6.15.15.1 No sanctions in place for the Medi-Cal program;
6.15.15.2 Resolution satisfactory to CalOptima of all identified Medi-Cal Program compliance deficiencies from the preceding calendar quarter;
6.15.15.3 Execution of all previous amendments; and
6.15.15.4 Other requirements contained in CalOptima Policy, as applicable.

6.15.16 During any period in which CalOptima provides funding for the PCC program, and written notice that the program is active, Physician shall provide PCC services in accordance with the following:

6.15.16.1 Physician shall employ PCCs and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. Physician shall staff one PCC per six hundred (600) CCS or SPD Members assigned to Physician. PCC

responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP. Physician shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence CalOptima Policy requirements.

6.15.16.2 CalOptima shall provide Physician the Profile requirements. Changes to the Profile which may impact PCC supplemental capitation, will be communicated to Physician thirty (30) days prior to the effective date of such change. If Physician is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30)-day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to Physician and termination of the Contract.

6.16 ADVANCE DIRECTIVES --- Physician shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. Physician shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- Physician shall provide, at its sole cost and expense, second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- Physician shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- Physician shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. The Physician shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- Physician shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. Physician shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, Physician and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

ARTICLE 7
Obligations of Physician – Reporting

7.1 DATA REPORTING REQUIREMENTS --- Physician shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. Physician shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- Physician shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies. Physician shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; Physician shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. Physician shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Physician shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon Physician should CalOptima determine that Physician is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- Physician agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Physician as related to Members. Physician shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If Physician is required to file monthly Financial Statements with the DMHC, Physician shall simultaneously file monthly Financial Statements with DHCS. Physician shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Physician shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- Physician shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting Physician's provider network.

7.6 PHYSICIAN ORGANIZATION PROFILE --- Physician shall report in compliance with CalOptima Policies, a profile of the Physician's organization, including, but not limited to, Physician's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- Physician shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by Physician, Physician shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, Physician shall provide copies of any Subcontract entered into or amended for purposes of fulfilling Physician's obligations under this Contract.

7.8 DISCLOSURE --- Physician and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of Physician's or Subcontractor's financial records related to Physician's capacity to bear the risk of potential financial losses, or the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that Physician, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, Physician shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized

disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Physician had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – Physician shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, Physician shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by Physician to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Physician's letterhead signed by the Physician's Chief Executive Office or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of Physician – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that Physician shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Physician at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which Physician received Capitation Payment and termination occurred, Physician shall be paid according to the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Physician shall make available

to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 Physician agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by Physician.

8.3 TERMINATION PLANS --- Physician shall have a plan for the orderly termination of services under this Contract. Physician shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60 days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- Physician acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and Physician shall notify DHCS of amendments to, or termination of, this Contract . Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Physician acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 Notice to the Department of Managed Health Care. In addition, Physician shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by CalOptima by multiplying the Capitation Rate set forth in Attachment E, by the number of Members enrolled with Physician, by age, gender and Aid Code.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to Physician on or about the fifteenth (15th) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with Physician.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from Physician an amount equal to twenty-five percent (25%) of the monthly Capitation

Payment (Withhold). CalOptima may adjust Physician's Capitation Payment on a quarterly basis should the Withhold fall below twenty-five percent (25%) of Physician's current month Capitation Payment. CalOptima may increase this withhold rate in accordance with CalOptima Policy.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the Physician. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Physician as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and Physician shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 OVERPAYMENTS AND CALOPTIMA RIGHT TO RECOVER --- Physician has an obligation to report any overpayment identified by Physician, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Physician, or of receipt of notice of an overpayment identified by CalOptima. Physician acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician, CalOptima shall have the right to recover such amounts from Physician by recoupment or offset from current or future amounts due from CalOptima to Physician, after giving Physician notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Physician to CalOptima, including, but not limited to, amounts due because of:

9.4.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.
9.4.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.
9.4.3 Unpaid Conlan reimbursements owed by Physician to a Member.
9.4.4 Capitation payments made in relation to a Member for a period after the Member was deceased.
9.4.5 In the event that DHCS or CMS establishes a Medicaid Medical Loss Ratio methodology that takes into account sub-capitated providers non-medical costs, amounts recovered from CalOptima by DHCS or CMS for failure to meet such MLR requirements, to the extent attributable to Physician's capitation

9.4.6 Payments made by CalOptima that are the financial responsibility of Physician.

In addition, in the event of termination of the Health Network, or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician paid by CalOptima against any funds owed to Physician by CalOptima, including, but not limited to, capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or Physician additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Physician any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by Physician.

9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Member assigned to Physician is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to Physician is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- In the event that an adult (age 21+ years) Member assigned to Physician

is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY---Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 FINANCIAL SECURITY REQUIREMENTS --- CalOptima shall designate amounts of funds Physician shall establish and maintain as financial security reserves. CalOptima shall identify in CalOptima Policies those financial instruments that shall be acceptable means for purposes of complying with financial security requirements. On a quarterly basis, CalOptima will calculate the minimum required financial security reserves and communicate in writing to the Physician any material deficits.

10.2 COMPREHENSIVE PHYSICIAN AUDIT --- CalOptima shall conduct and Physician shall agree to a full comprehensive compliance audit to be conducted at Physician administrative offices and/or Facilities annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the Physician audit in writing to Physician. Physician may rebut and dispute audit findings pursuant to CalOptima Policies. Physician is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. Physician acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from Physician.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each Physician's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the Physician accurately reported all Encounters.

10.4 APPROVED DRUG LIST --- CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

10.5 REVIEW OF OFF-APPROVED DRUG LIST PRESCRIPTIONS --- CalOptima shall review off-Approved Drug List prescriptions in a timely manner pursuant to CalOptima Policies.

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the

provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current MOUs entered into by CalOptima that are binding on Physician. Copies of current MOUs entered into by CalOptima that are binding on Physician may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for Physician interpretation of MOUs entered into by CalOptima that are binding on Physician. Interpretation of MOUs will identify duties, obligation and responsibilities of Physician.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- Physician acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to Physician, information and data relating to the performance of Physician that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Physician, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. Physician complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to Physician the financial risk assumed under the Contract by providing to Physician the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Physician, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major

expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to Physician the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to Physician sufficient details to allow Physician to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all Physician, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF PHYSICIAN TERMINATION PLANS --- CalOptima shall review and approve Physician termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release Physician's capitation withhold to Physician upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by Physician of all post-termination

requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply Physician's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 RELEASE OF FINANCIAL SECURITY REQUIREMENT DEPOSITS --- CalOptima shall release to Physician financial security requirement deposits no less than six (6) months following the termination of this Contract unless termination is the result of Physician insolvency. CalOptima shall release to Physician financial security requirement deposits no less than twelve (12) months following the termination of this Contract if termination is the result of Physician insolvency.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- Physician may contract with out-of-county facilities for Covered Services for CalOptima Members provided that Physician ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

12.2 MEMBER LIAISON PROGRAM (MLP) --- Physician shall establish and maintain support for the Member Liaison Program, including but not limited to:

12.2.1 Providing SPD Members and their caregivers with assistance to navigate the Medi-Cal managed care system;

12.2.2 Coordinating the range of Covered Services needed by SPD Members and assisting SPD Members in understanding and utilizing Physician's referral process;

12.2.3 Ensuring SPD Members receive appropriate and timely referrals;

12.2.4 Identifying barriers faced by SPD Members and integrating recommendations into the delivery system to improve access;

12.2.5 Keeping Physician and Participating Providers educated and sensitive to the needs of persons with disabilities;

12.2.6 Assisting PCPs to fully understand individual SPD Members' needs and provide physicians with access to the many community based resources available;

12.2.7 Providing feedback to CalOptima regarding necessary program modifications/enhancements;

12.2.8 Providing access to SPD Members information necessary for coordination of Covered Services across all Physician departments;

12.2.9 Assisting in the promotion, outreach and community awareness of the MLP.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If Physician fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards, are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Physician's Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements; (xvi) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvii) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xviii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations. CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the Physician or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP..

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus the administrative fee from the Physician's Capitation Payment.

13.1.2.2 Physician may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause – Notwithstanding, and in addition to, any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. Physician may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. Physician shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, Physician shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of Physician.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the Physician in the event that Physician's membership falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of Physician's membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should Physician fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should Physician fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to Physician that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should Physician fail to comply with requirements for Physician's organization and operation structure established in this Contract and CalOptima Policies.

13.8 Not Applicable to this Contract.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred twenty (120) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR PHYSICIAN INSOLVENCY --- If Physician becomes insolvent, Physician shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1. In the event of the filing of a petition for bankruptcy by or against Physician or a principal Subcontractor, Physician shall assure that all Physician's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician until Physician fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Physician obligations have been met.

13.11 TERMINATION BY PHYSICIAN FOR CAUSE --- Provided that Physician is not in default hereunder, Physician may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation

Payment due to Physician under this Contract. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to Physician any such past due payments.

13.12 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW--- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contract, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Physician in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Physician shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO PHYSICIAN --- CalOptima may establish key performance measures of Physician to set minimum contract performance thresholds and/or pay financial incentives to Health Networks and Physician groups. CalOptima may take the following actions, at it sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against Physician, terminate this Contract, and establish Capitation Rates and other payments to Physician.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- Physician agrees as follows:

13.14.1 CalOptima reserves the right to require Physician, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members. Imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that Physician Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that Physician terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks or Physician groups, Physician shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance

with Section 13.9 prior to the end date of the Contract term in the event Physician elects not to participate in any extension period or new contract term.

13.16 Not Applicable to this Contract.

13.17 EXTENSION, RENEWAL, OR MODIFICATION – Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. Physician has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF PHYSICIAN --- CalOptima and Physician agree that Physician and any agents or employees of Physician, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE--- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. Physician shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY --- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

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

14.10 ASSIGNMENT OR DELEGATION ---Physician agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima , as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Physician or Subcontractor; (iii) the merger, reorganization, or consolidation of Physician or Subcontractor with another entity with respect to which Physician or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Physician or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Physician or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the Physician agrees to comply with applicable Federal suspension and debarment

regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

14.13.1 By signing this Contract, the Physician certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

14.13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

14.13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

14.13.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.13.2 If the Physician is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.13.4 If the Physician knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Physician certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION—

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Section 14.16.2.2.

14.16.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment F, entitled "Standard Form-LLL Disclosure of Lobbying Activities") if such recipient has made or has agreed to make any payment using non-appropriated funds to include profits from any covered federal action in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in this Section of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered

federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima
Attention: Director of Contracting
505 City Parkway West
Orange, California 92868
To: Physician
_____
_____
_____
_____

14.18 GOVERNMENT CLAIMS ACT --- Physician shall ensure that Physician and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code sections 900 et seq.), including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

ARTICLE 15
Signatures

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE MARCH 1, 2022 THROUGH JUNE 30, 2022.

IN WITNESS WHEREOF, CalOptima and **ARTA Western California, Inc. dba Optum** have executed this Contract:

FOR PHYSICIAN: FOR CALOPTIMA:

SIGNATURE	SIGNATURE
PRINT NAME	Yunkyung Kim PRINT NAME
TITLE	Chief Operating Officer TITLE
DATE	DATE

ATTACHMENT A- (EFFECTIVE 07/01/2019)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Physician	Hospital Budget	Other
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	**-See Transportation-**		
Amniocentesis	**X**		
Anesthesia-for medical diagnosis (Includes Medical, Dental, Mental Health, etc….)			
Professional component	**X**		
Facility component		**X**	
Birth Control	**-See Family Planning-**		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			**CalOptima (Claims)**

	Physician	Hospital Budget	Other
CHDP	**-See Pediatric Preventative Services-**		
Chemotherapy			
Professional component	**X**		
Outpatient Facility component		**X**	
Medication	**-See Medication-**		
Chiropractic Services	**X**		
Cosmetic Surgery (Medically Necessary)			
Professional component	**X**		
Facility component (licensed surgical center or acute care facility only)		**X**	
Dental Services			
General dental services-Including teeth			**Denti-Cal**
Oral Maxillofacial Surgery (Repair or accident/injury; medically necessary-Excluding teeth)			
Professional component	**X**		
Facility component		**X**	
Anesthesia Services			
Professional component (Other than provided by Dentist)			
Professional component (Provided by Dentist)			**Denti-Cal**
Facility component			
Detoxification – Medical (inpatient acute medical facility only)			
Professional component	**X**		
Facility component		**X**	
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs, solutions, or other required for the service)			
Professional component	**X**		
Facility component	**X**		
Diagnostic Services (Inpatient), Including Radiology			
Professional component	**X**		
Facility component		**X**	
Dialysis			
Professional component	**X**		
Facility component		**X**	
Durable Medical Equipment (DME) (including insulin pumps)			
Inpatient		**X**	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings, blood glucose meters)	**X**		
Custom Wheelchair Assessment	**X**		

	Physician	Hospital Budget	Other
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		**X**	
Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**		
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions and the technical component of diagnostic testing.		**X**	
Mental Health Post Triage / Emergency Stabilization Treatment – admitted to inpatient psychiatric facility			**OC HCA/ State**
EPSDT Supplemental Services			
Acupuncture	**X**		
Autism Screening	**X**		
Audiology	**X**		
Chiropractic	**X**		
Cochlear Implant	**X**		
Dental Services			**State**
EPSDT Case Management	**X**		
Hearing Aid Batteries	**X**		
In-Home Private Duty Nursing (PDN)	**X**		
Medical Nutrition Services	**X**		
Occupational Therapy	**X**		
Orthodontic Services			**Denti-Cal**
Pediatric Day Health Care Services			**State**
Speech Therapy	**X**		
Mental Health – Specialty Outpatient			**OC HCA/ State**
Family Planning (all provider types)			
Professional component	**X**		
Surgically implanted sterilization devices		**X**	
IUDs (with or without medication)	**X**		
Contraceptive items and supplies by a non pharmacy provider (excluding oral, injectable, topical and implantable contraceptive medications)	**X**		
Attachment C contraceptive items/ supplies when provided by CalOptima PBM Pharmacy			**CalOptima (Pharmacy)**
Oral, Implantable, topical and Injectable medications	**-See Medications-**		

	Physician	Hospital Budget	Other
Genetic Disease Screening			
Prenatal Triple Marker Screening			***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening			***DHCS Genetic Disease Branch***
Newborn screening panel		**X**	
Other Genetic Testing/Counseling	**X**		
Hearing Aids	**X**		
Hearing Screening	**X**		
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			**OC HCA / State**
Injectable medications	***-See Medication -***		
Home infusion	***-See Medication -***		
Home Health and Home Infusion Pumps & Supplies		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization – Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided In lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			**OC HCA / State**
Hyperbaric Oxygen Therapy		**X**	
Injectables	***- See Medications -***		
Immunizations	***- See Preventive Services -***		
Laboratory Services			
Inpatient – Medical (technical component)		**X**	
Inpatient – Psychiatric			**OC HCA / State**
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room	***- See Emergency Services -***		
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			**CalOptima (Claims)**
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	

	Physician	Hospital Budget	Other
Outpatient Medical/Surgical Supplies and Dressings			
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy			***CalOptima (Pharmacy)***
All other Medical Supplies1[2]	**X**		
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/ State***
Long Term Care Facility			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM.			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by Non-Pharmacy Providers. Includes physician administered oral and injectable, topical and implantable drugs including chemotherapeutic medication			***CalOptima (Claims)***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products -***		
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)			**DHCS**
Mental Health			
Behavioral Health Professional Services			
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing			***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit			***OC HCA/ State***
Electroconvulsive Treatment (psychiatrist)			***OC/HCA/ State***
Applied Behavior Analysis (ABA)			***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)		**-In OC- Service is NOT a Medi-Cal Benefit-**	
Behavioral Health Facility			
Acute Care Facility ER not resulting in psych admission			
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit			**OC/HCA/ State**
Patial Hospitalziation Program or Intensive Outpatient PHP, IOP		**-In OC-Service is NOT a Medi-Cal Benefit-**	
Electroconvulsive Treatment Outpatient		**X**	

	Physician	Hospital Budget	Other
Substance Use Disorder (SUD) Professional			
Outpatient-Office-Mild to Mod, Medication Assisted Ttreatment (MAT)-Psychiatrist			**CalOptima (Claims)**
Outpatient-DMC Provider, Intensive Outpatient - DMC Provider			**Drug Medi-Cal**
ER-SUD Consultation			**CalOptima (Claims)**
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**		
Substance Use Disorder (SUD) Facility			
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)		**X**	
Acute Care Facility (Voluntary Inpatient Detox)			**FFS Medi-Cal**
Residential (Detox/Rehab)			**Drug Medi-Cal**
Neuropsych Testing	**X**		
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Products			
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9)			***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**		
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**		
Observation			
Professional component	**X**		
Facility component		**X**	
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	
Occupational Therapy	***- See Rehabilitation -***		
Orthotics	**X**		

	Physician	Hospital Budget	Other
Outpatient Diagnostic Services	***-See Diagnostic Services (Outpatient) -***		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	***- See Medication -***		
Physical Therapy	***- See Rehabilitation -***		
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Preventive Services- Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
Vaccine			***VFC (Vaccines for Children Program)***
Administration fee	**X**		
Prosthetic Devices			
Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		
Radiation Therapy			
Professional component	**X**		
Facility component		**X**	
Radiology Services	***- See Diagnostic Services -***		
Rehabilitation – Physical, Occupational, & Speech Therapy			
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Outpatient professional component	**X**		
Outpatient facility component	**X**		
Long Term Care Facility	**X**		
Skilled Nursing Facility			
Custodial – Long Term Care	***- See Long Term Care Services -***		
Short stay	***- See Hospitalization -***		
Speech Therapy	***- See Rehabilitation -***		
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	**X**		
Facility component		**X**	
Transgender Services			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital Budget	Other
Transplants – Including Procurement			
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)			***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)			***CalOptima (Claims)***
All Other Transplants (e.g. bone graft, cornea, skin)			
Professional component	**X**		
Facility component		**X**	
Transportation (includes ambulance)			
Emergency		**X**	
Non-Emergency Medical Transportation (NEMT)		**X**	
Non-Medical Transportation (NMT)			***CalOptima (Claims)***
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA			***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**		
Vision Care			
Routine adult and child eye refraction examination			***CalOptima (TPA)***
Contact lenses			***CalOptima (TPA)***
Lenses and Frames			***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**		
Intraocular lens – surgically implanted		**X**	
Ophthalmological services	**X**		
Prosthetic eye	**X**		
Whole Child Model-Previously California Children's Services			
Professional component including all Special Care Center services billable on a professional claim	**X**		
Facility component including all Special Care Center services billable on a facility claim		**X**	
Maintenance and Transportation			***CalOptima (Claims)***
Medical Therapy Program			***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.			
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***			

ATTACHMENT B

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____

_____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ATTACHMENT C
Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

	Item	Limitation
Respiratory Items		
	Inhaler Assist Devices	1/Year
	Nasal Aspirator	1/Year
	Peak Flow Meters, Non-Electric	1/Year
Contraceptive Items		
	Condoms	1 Box of 12/Month
	Diaphragms	1/Year
Diabetic Supplies		
	Blood Glucose Monitors	1 Every 3 Years
	Insulin Syringes	100/Month
	Lancets	100/Month
	Lancet Auto Injectors	2/Year
	Blood Glucose Test Strips	100/Month
	Urine Test Strips	100/Month
	Alcohol Pads	200/Month

ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

ATTACHMENT E
Capitation Rates

Effective July 1, 2019

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Family/Poverty/Child	0 year, Both			
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Low Income Children Program (formerly Healthy Families)	0 year, Both			
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Adult	All Ages Both			
Aged	All Ages, Both			
Disabled	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
ESRD - Family	All ages, Both			
ESRD - Poverty	All ages, Both			
ESRD - Child	All ages, Both			

ESRD - Adult	All ages, Both			
ESRD - Aged	All ages, Both			

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD - Disabled	All ages, Both			
ESRD - MCX	All ages, Both			
ESRD - MSI	All ages, Both			
AIDS - Family	All ages, Both			
AIDS - Poverty	All ages, Both			
AIDS - Child	All ages, Both			
AIDS - Adult	All ages, Both			
AIDS - Aged	All ages, Both			
AIDS - Disabled	All ages, Both			
AIDS - MCX	All ages, Both			
AIDS - MSI	All ages, Both			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Whole Child Model Base Capitation Rates

The following Whole Child Model payment provisions are effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program.

The following base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

	Hospital	Physician	Total Capitation
Whole Child Model			

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Funding for PCC

In addition to those amounts described above, HMO shall receive ($) per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups. CCS member is identified by their CCS Eligible condition as determined by the local CCS Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Members with a CCS Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E–1

Capitation Rates for Adult Expansion Members

Effective July 1, 2019 through June 30, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Physician.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Physician to remit the portion of the difference attributed to Physician.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Physician.

Aid Code	Age & Gender	Base Cap Rate		
Category	Category	Hospital	Physician	Total
Expansion (MCX)	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
Expansion (MSI)	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			

For services rendered to Adult Expansion Members, Physician shall reimburse Specialist Physicians, in the aggregate, at least % of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment F-1 is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

- Payment rates shall be as follows:

- Physician payment
- Hospital payment

Funding for PCC – Effective October 1, 2018

In addition to those amounts described above, HMO shall receive ($) per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups and CCS member is identified by their CCS Eligible Condition as determined by the local CCS Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Member's with a CCS Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements

ATTACHMENT E-2

Shared Risk Program

1. Shared Risk Pool. CalOptima and Physician are establishing the Shared Risk Pool as described in this Attachment, which shall be administered by CalOptima and separately accounted for on CalOptima's books. As provided in the previous contract, any Shared Risk Pool deficits remaining at the end of the reconciliation of the final year of the previous contract and any expenses from a previous Shared Risk Period received after the end of that pervious Shared Risk Pool reconciliation period shall be carried forward in the Shared Risk Pool under this Contract. Any deficits remaining at the end of the reconciliation of the final year of this Contract and any late-received expenses for that final year shall similarly be carried forward to any subsequent shared risk contract.

1.1 Shared Risk Services—Definition. Shared Risk Services means all Covered Services that are designated under the caption "Hospital Budget" set forth in Attachment A of this Contract. The amounts or rates that CalOptima will pay to Hospitals for the provision of Shared Risk Services to Members are set forth in the Hospital Services Contract entered into with the participating Hospitals ("Shared Risk Hospital Amount(s)"). Non-Hospital providers of services contained within the "Hospital Budget" shall be paid according to their individual contract rates. Payments made to Hospitals under CalOptima's Health Network carve-out programs, such as the "special tertiary rate" and "high-cost exclusions," shall not be included in Shared Risk Services.

1.2 Shared Risk Budget. In addition to the Hospital Budget Capitation Allocation to the Shared Risk Pool set forth in Section 1 of this Attachment, the Shared Risk Budget shall include the following amounts received by CalOptima or any Hospital in connection with any Shared Risk Services provided to Members: (a) monies recovered from coordination of benefits, and (b) any reinsurance coverage amounts collected or allocated. Shared Risk Costs shall be the actual amounts paid for Shared Risk Services less any recoveries, including, but not limited to, overpayments.

1.3 Shared Risk Expenses. Monthly, during the term of this Contract, the following expenses and charges ("Shared Risk Expenses") shall be deducted from the Shared Risk Budget: (a) the actual Shared Risk Hospital Amounts paid to Hospitals for Shared Risk Services provided to Members, (b) any reinsurance premiums paid by CalOptima that are allocable to the shared risk pool, (c) an estimated amount of IBNR expense (defined below) as reasonably determined by CalOptima (with the final IBNR expense determined in accordance with and as set forth in Section 1.5.1 below), and (d) administrative expenses at a rate of one dollar and sixty cents ($1.60) per Member per month. Any applicable copayments, deductibles or third-party payments collected by CalOptima or Hospitals for Shared Risk Services provided to Members shall be deducted from Shared Risk Expenses.

1.4 Shared Risk Pool – Quarterly Report and Semi-Annual Reconciliation and Adjustment.

1.4.1 Within forty-five (45) days following the end of each calendar quarter during each Shared Risk Period (defined below), CalOptima shall produce a written report showing all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool during that quarter and the Shared Risk Period to date. Each

quarterly Report shall include an estimate of the projected Budget Deficit or Budget Surplus (as such terms are defined in, and as determined consistent with, Section 1.5) determined by annualizing the aggregate amount of the Shared Risk Budget and the Shared Risk Expenses for all months to date in the applicable Shared Risk Period.

1.4.2 Within sixty (60) days of the end of the semi-annual distribution period, which shall be defined as July 1 through December 31 of each Shared Risk Period, CalOptima shall compute the status of the Shared Risk Pool for that semi-annual period as follows: Hospital Budget Allocations made in that semi-annual period minus claims paid for services rendered in that semi-annual period minus a full allocation for Incurred But Not Reported (IBNR) claims based on historical experience with the applicable CalOptima population for that semi-annual period. If the status thus computed shows a surplus, CalOptima shall pay to Physician, from the Hospital Budget Allocation, an amount equal to sixty percent (60%) of such surplus. Any surplus distributions are an advance against the projected final surplus. If the amount is a deficit, it shall be carried forward to the year-end reconciliation.

1.5 Shared Risk Pool -- Year-End Reconciliation and Settlement. The Shared Risk Pool shall be administered on a fiscal-year basis (July 1 through June 30) ("Shared Risk Period").

1.5.1 Within one hundred twenty (120) days following the close of each Shared Risk Period, CalOptima shall audit and reconcile, and produce a written report thereof, all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool. Risk Pool Expenses for any Shared Risk Period identified after the audit, reconciliation and settlement of the Shared Risk Pool for the applicable Shared Risk Period shall be rolled forward to the next succeeding Shared Risk Period. The reconciliation and settlement of the Shared Risk Pool shall take into account incurred but not reported ("IBNR") expenses, regardless of when paid, provided that only those expense items received within (90) days after the end of the current Shared Risk Period shall be included in the computation of the IBNR expense for such Shared Risk Period.

1.5.2 Deficit. If, for any Shared Risk Period, Shared Risk Expenses exceed the Shared Risk Budget (such excess referred to herein as the "Budget Deficit"), an amount equal to sixty percent (60%) of such Budget Deficit, plus the amount of any Semi-Annual distributions, shall be carried forward as a charge against any future distributions under section 1.5.3.

1.5.3 Surplus. If, for any Shared Risk Period, the Shared Risk Budget exceeds the Shared Risk Expenses (such excess referred to herein as the "Budget Surplus"), an amount equal to sixty percent (60%) of such Budget Surplus shall be paid to Physician by CalOptima only after any Semi-Annual distributions have been deducted from the sixty percent (60%) of the Budget Surplus allocable to Physician.

1.5.4 If Physician elects to move from existing contracted shared risk group model to another contract model, Physician's shared risk pool shall not be in deficit.

2. eports and Timely Settlement. CalOptima shall be responsible for maintenance of records and development of reports required for administration of the Shared Risk Pool.

Physician shall have thirty (30) days following receipt to review annual reports produced by CalOptima under Section 1.5.1 above. Absent reasonable objections in such thirty (30) day period, such annual reports shall be considered final, and any and all payments of Budget Surplus shall be made within fifteen (15) days following the expiration of the 30 day review period.

3. Settlement in the Event of Termination. Notwithstanding anything in this Attachment or elsewhere in this Contract, if this Contract is terminated, in accordance with the provisions of Article 13 of this Contract, the Shared Risk Pool shall be settled within one hundred twenty (120) calendar days following the termination of this Contract in accordance with Section 1.5 of this Attachment.

4. Obligations of Physician. Within seventy-two (72) hours following notification of an admission of a Member to any Hospital, Physician shall provide CalOptima with a report in a form acceptable to CalOptima. If, in CalOptima's reasonable opinion, Physician consistently fails to provide such reports to CalOptima, Physician shall be deemed in breach of this Contract, and CalOptima may take all actions permitted under this Contract, including termination of this Contract for cause.

5. Prohibition on Other Agreements with Hospitals. During the term of this Contract, Physician shall not enter into any agreement with any Hospital with respect to the Members assigned to Physician without the prior written approval of CalOptima, and upon any violation of this provision by Physician, this Contract shall be subject to termination pursuant to Section 13.1. of the Contract.

6. IBNR Calculations. For purposes of this Contract, IBNR shall be calculated using Medi-Cal population lag studies to generate completion factors to apply against claims paid to date. If membership is significant enough or if there is a significant change in bed days, as determined by CalOptima, then alternative calculations may be used, separating the combined TANF aid categories from all others, and acute inpatient expenses from all other Hospital Budget expenses. Year-end IBNR will be calculated using claims paid data through ninety (90) days after the end of the Shared Risk Period. The year-end settlement report will note the "claims paid through" date, and subsequent claims paid for that Shared Risk Period will be recorded against the next Shared Risk Period.

7. Termination for Poor Performance. Budget Deficits in two successive Shared Risk Periods shall, at CalOptima's sole discretion, constitute cause for termination under Section 13.1.

ATTACHMENT E-3

DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and Physician shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Physician which Physician agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-3) effective July 1, 2017 and CalOptima agrees to pay Physician an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-3.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-3:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with Physician to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    a. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    b. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. Physician shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-3, applicable state and federal requirements and CalOptima policies. Physician shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-3 in addition to any payment paid by Physician to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by Physician for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by Physician, in accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by

CalOptima in order for it to fulfil state and federal obligations related to the Prop 56 Increase, CalOptima will reimburse Physician for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by Physician more than one year after the date of service.

4. Physician shall not provide supplemental Prop 56 payments under this Attachment E-3 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by Physician.

5. On a monthly basis, Physician must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-3, either directly by Physician or by Physician's delegated entities and subcontractors at Physician's direction. Reports shall include all supplemental Prop 56 payments made during the month. Physician must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. Physician, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay Physician a two percent (2%) administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by Physician to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on confirmed Prop 56 increase payments and shall be remitted to the Physician.

7. CalOptima's obligation to pay Physician any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to Physician if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. Physician shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 2017 and after.

9. Physician acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, Physician shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. Physician agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. Physician and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, Physician shall ensure that the requirements of this Attachment E-3 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. Physician shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, Physician shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Physician, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

ATTACHMENT E-3, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

Physician shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to Physician prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-3.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-3, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

Physician shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to Physician. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-3, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by Physician no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

ATTACHMENT F –1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT F – 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

MEDI-CAL

PHYSICIAN – SHARED RISK

AMENDED AND RESTATED

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

TALBERT MEDICAL GROUP, P.C. DBA OPTUM

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AMENDED AND RESTATED
CONTRACT FOR HEALTH CARE SERVICES

PHYSICIAN
(Shared Risk)

THIS CONTRACT FOR HEALTH CARE SERVICES ("Contract") is entered by and between Orange County Health Authority, a public agency, dba CalOptima, ("CalOptima"), and **Talbert Medical Group, P.C. dba Optum,** ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. Physician is a California professional medical corporation, which employs or otherwise contracts with physicians who are physicians licensed to practice medicine in the State of California.

D. Physician desires to provide or arrange for the provision of Covered Services to Members as defined herein.

E. CalOptima and Physician desire to enter into this Contract on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the Physician and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 "Advance Directive" means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 "Aid Code" means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 "American Indian" means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 "American Indian Health Care Provider" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.7 "American Indian Health Service Programs" means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000.

1.8 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

1.9 "California Children's Services (CCS)" means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or Physician group.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Physician, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designee, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the Physician by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by Physician's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi-Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or Physician group or from one Health Network or Physician group to another Health Network or Physician group; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq., that covers certain pediatric preventive services for children eligible for Medi-Cal. .

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 "Community Liaison" or "CL" means an individual designated to perform the duties set forth in this Contract and CalOptima Policies, as part of the Community Liaison Program.

1.23 "Community Liaison Program" or "CLP" means a program created and operated by CalOptima to facilitate access to Covered Services and coordination of care for SPD Members enrolled in a Health Network or Physician group.

1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes basic case management.

1.25 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and Physician. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on Physician, DHCS Medi-Cal Managed Care Policy Division Policy Letters.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22, of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network or Physician group regardless of Health Network or Physician group reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the Hospital for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the Hospital(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their

children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act").

1.45 "Health Network" means a physician hospital consortium (PHC), physician group under a shared risk contract, or health care service plan, such as an HMO, as defined

in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act) and having a Hospital Services Contract with CalOptima.

1.49 "Incontinence Supplies" means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 "Joint Commission" means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 "Management Services Organization" or "MSO" means any organization, firm, company or entity providing Administrative Services on behalf of Physician which impact CalOptima Members.

1.53 "Medi-Cal" is the name for the Medicaid program in the State of California, and "Medicaid" is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 "Medi-Cal Fee Schedule" means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedure at the Federal or State levels. The Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When

determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v).

1.57 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 "Medical Screening Examination" or "MSE" means an examination within Physician's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD)) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and assigned to Physician.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU" means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks, Physician groups and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled with Physician.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with Physician or Hospital to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of Physician. All Participating Providers shall be considered Subcontractors.

1.71 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 "Pediatric Preventive Services" or "PPS" means well child services which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.76 "Physician" means a group practice, independent practice association or other formal business arrangement comprised of individuals, each of whom hold an unrestricted license to practice medicine or osteopathy in the state in which they practice, and which participates with a Hospital in a PHC or holds a shared risk contract with CalOptima.

1.77 "Physician Incentive Plan" means any compensation arrangement between Physician and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.78 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 "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.

1.80 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.81 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.82 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.83 "Reinsurance" means coverage provided by CalOptima and any coverage secured by Physician, which limits the amount of risk or liability for the cost of providing Covered Services.

1.84 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a primary care physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

1.85 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing

1.86 "Shared Risk Pool" means the risk sharing program, described in Attachment E hereto, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and Physician.

1.87 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes.

1.88 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.89 "Specialized Durable Medical Equipment" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.90 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.91 "Specialty Mental Health Services" means:

1.91.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.91.2 Psychiatric inpatient hospital services;

1.91.3 Targeted Care Management services;

1.91.4 Psychiatrist services;

1.91.5 Psychologist services; and

1.91.6 EPSDT supplemental specialty mental health services.

1.92 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.93 "State" means the State of California.

1.94 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.95 "Subcontract" means an agreement entered into by the Physician with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract.

1.96 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Physician. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates.

1.97 "Sub-delegation" means the process by which Physician expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by Physician in order to meet its obligations under, and the intent of this Contract.

1.98 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, APL 17-011, or any update or revision thereof.

1.99 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.100 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.101 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
Obligations of Physician – Financial

2.1 FINANCIAL SECURITY REQUIREMENTS --- Physician must establish and maintain, throughout the term of this Contract, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, equal to fifty-thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one month's Capitation Payment.

Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit.

2.2 INDEMNIFICATION --- Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

2.3 INSURANCE REQUIREMENTS---

2.3.1 Professional/Medical Malpractice:

Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician :
$1,000,000 per incident/$3,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:

Physician and each Participating Provider shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate

Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:

Physician and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:

$1,000,000 Bodily Injury by Accident - each accident

$1,000,000 Bodily Injury by Disease - policy limit

$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:

Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:

$10,000,000 each claim/$10,000,000 aggregate

2.3.5 Insurer Ratings ---
Such insurance shall be provided by an insurer:

(a) rated by A.M. Best with a rating of A V or better; and

(b) "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

2.3.6 Captive Risk Retention Group/Self Insured:

Where any of the Insurance(s) mentioned in this Section are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.7 Cancellation or Material Change:
The Shared Risk Group shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.8 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance shall be provided to CalOptima prior to execution of the Contract and annually thereafter.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT --- Physician shall reimburse the Local Health Department (LHD) on a FFS basis, according to the current Medi-Cal Fee

Schedule, for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 PHYSICIAN FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- Physician shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 AS SET FORTH IN ATTACHMENT A, the Division of Financial Responsibilities, Physician shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment with the exception of certain Medical Supplies as set forth in Attachment C.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.6 Not Applicable to this Contract.

2.7 PHYSICIAN PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - Physician and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

2.7.2 Claims Turnaround Time - Physician shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician, unless the claim or portion thereof is reasonably contested by Physician, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician in accordance with CalOptima Policy.

2.7.3 Claims Adjudication – Except as provided in this Section, Physician shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.7.4 Dispute Resolution - Physician shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - Physician shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of Physician

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If Physician does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that Physician fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from Physician for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that Physician fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from

Physician for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce Physician Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of Physician, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

2.7.8.1 Physician shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Physician's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 Physician shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of Physician, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 Physician's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 Physician shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the physician group. Physician will receive misdirected claims per CalOptima Policy.

2.7.9.2 Physician shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy and load them into their system to ensure timely claims processing.

2.7.10 FQHC Payments – If FQHC, Physician shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services.

2.7.11 American Indian Health Service Payments - Physician shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. Physician shall reimburse the American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in Physician's provider network, Physician shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy.

2.7.13 Family Planning Provider Payments - Physician shall reimburse non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy. Physician shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.7.14 Sexually Transmitted Disease Treatment Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Physician may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Physician along with billing information.

2.7.15 HIV Testing and Counseling Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in CalOptima Policy. Physician shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Physician.

2.7.16 Information Disclosures To Participating Providers Physician shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments –

2.7.17.1 Physician shall reimburse contracted Specialist Physician for Covered Services rendered to Members on an aggregate basis, at an amount equal to or greater than one hundred thirty-three percent (133%) of the Medi-Cal fee schedule except for those members specified below.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by Physician and the physician and surgeon.

2.7.18 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- Physician shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- Physician shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by Physician and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall Physician cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased

Members. Physician shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. Physician shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS; or in child support enforcement cases. If Physician does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then Physician shall follow the procedure above for cost avoidance. If Physician does not reimburse a Provider on a Fee-for-Service basis, then Physician shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 Physician shall have written policies implementing these requirements.

2.9.4 Physician shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 Physician shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 Physician shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 Physician shall demonstrate to CalOptima that where Physician does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Physician projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- Physician shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%) when combined with the revenues and expenses of the Shared Risk Pool, which are identified in Attachment E.

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- Physician shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. Physician shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care that are required under Section 1300.75.4.2 of Title 28 of the California Code of Regulations.

2.12 COOPERATION WITH DMHC --- Physician shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to Physician, in accordance with Section 1300.75.4.7 of Title 28 of the California Code of Regulations. Physician shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process, in accordance with Section 1300.75.4.8 of Title 28 of the California Code of Regulations.

2.13 Not Applicable to this Contract.

ARTICLE 3
Obligations of Physician - Administrative

3.1 Not Applicable to this Contract.

3.2 EQUAL OPPORTUNITY

3.2.1 Physician 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. Physician and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth

the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Physician and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

3.2.2 Physician and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Physician and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.2.3 Physician and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Physician and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 Physician and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.2.5 Physician and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.2.6 In the event of Physician and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.2.7 Physician and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Physician and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Physician and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Physician and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- Physician shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- Physician shall display the CalOptima logo on all Physicians' written communication to Members pursuant to CalOptima Policies, and in a manner such that it is clear to the Member that the communication is referring to the CalOptima program. Physician shall not otherwise use CalOptima's logo for any business unrelated to this Contract.

3.5 MEMBER INQUIRIES AND CALLS --- Physician shall establish and maintain a call center for receiving and responding to Member inquiries and calls. Physician's call center shall meet requirements established by CalOptima Policies. Physician

shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure Physician will be able to supply call center reports as required by CalOptima Policies.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, Physician shall ensure that all written Member information provided by Physician to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. Physician shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by a Physician. Physician shall implement and comply with CalOptima Policies relating to Member grievances. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by Physician. Physician shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES.

Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, Physician may sub-delegate to an MSO, medical group, and/or IPA administrative functions required of Physician but shall not absolve Physician of oversight responsibilities. All sub-delegation must be approved by CalOptima. Physician shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. Physician's sub-delegation to another entity does not alter Physician's ultimate obligation and responsibilities set forth in this Contract. Physician may give a sub-delegate the authority to act on behalf of Physician; but Physician retains oversight and accountability for the sub-delegated function. Accountability means that Physician cannot abdicate responsibility for the function being performed according to the requirements of this Contract, Physician's standards and those

established by this Contract and CalOptima Policies. Physician is accountable for all functions performed in its purview whether by Physician, by any sub-delegate or by any sub-sub-delegate. If Physician chooses to sub-delegate a function, Physician must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its Membership and provider network. At a minimum, Physician shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the Provider and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the Physician and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the Physician evaluates the sub-delegate entity's performance; and

3.8.1.5 The Physician's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the Physician's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the Physician's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The Physician's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The Physician's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 Physician shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 Physician shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of Physician's Members, including those receiving services from a sub-delegate of Physician.

3.8.6 Physician shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve (12) month period. Physician shall establish standards and performance requirements for the sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of Physician in this Contract and in CalOptima Policies. Physician may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network or Physician group, or as a participant in a Health Network (i.e. a Shared Risk Group, PHC Physician Group or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by Physician to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. Physician shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. Physician shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- Physician may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Physician is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Physician is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. All subcontracting with an offshore entity must be approved by CalOptima prior to execution of the Subcontract. Additionally, Physician shall require all Subcontracts that relate to the provision of Covered Services, include the following:

3.9.1 An agreement to make all premises, facilities, equipment, books records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the

establishment and maintenance of and access to Medical and Administrative Records as set forth in Sections 3.17 to 3.22 of this Contract;.

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10 and 7.11 of this Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or Physician, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on Physician;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in the same manner as those services are provided to other patients;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services, and State Contract (Exhibit A, Attachment 8, Provision 13) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify Physician of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; and (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, as set forth in Attachment D of this Contract, which shall

be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event Physician cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with Physician and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract.

3.9.15 In the event that Physician implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by Physician.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Physician delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract (including the Delegation Acknowledgement and Acceptance Agreement);

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or Physician determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the Physician to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Subcontractors are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program.

3.10 PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- Physician shall comply with the following organization and operations structure requirements:

3.10.1 Single Board of Directors and management team.

3.10.2 Medical Director/CMO providing full time coverage. Duties shall include:

- Ensuring that medical decision are:
  - Rendered by qualified medical personnel
  - Are not unduly influenced by fiscal or administrative management considerations.
- Ensuring that the medical care provided meets the standards for acceptable medical care.
- Ensuring that medical protocols and Standards of Conduct for medical personnel are followed.
- Developing and implementing medical policy.
- Resolve grievances related to medical quality of care.
- Have a role in the implementation of Quality Improvement activities.

- Actively participate in the functioning of the grievance procedures.

- Actively participate in Quality activities including Credentialing and Peer Review.

- Acts as liaison and participates with CalOptima in any activities related to Medical Director/CMO duties.

PHYSICIAN shall report to CalOptima any changes in the status of its Medical Director within ten (10) calendar days.

3.10.3 No employee of Physician, including but not limited to Medical Director(s) and/or the Chief Medical Officer, that make decisions regarding the authorization and/or provision of Covered Services to Members shall have a financial incentive or otherwise benefit financially from decisions made regarding authorization and/or provision of Covered Services to Members, nor shall such an employee have any fiscal or administrative duties or responsibilities that may unduly influence medical judgments.

3.10.4 Single Credentialing Committee and credentialing policies, procedures and standards.

3.10.5 Single and unified health care delivery system including but not limited to:

3.10.5.1 Participating Providers must be accessible to all members enrolled with Physician.

3.10.5.2 Members can select any contracted PCP with an open panel.

3.10.5.3 A PCP can refer members to any contracted specialist.

3.10.5.4 Physician must report to CalOptima all required data for the total enrollment of the Physician and the total provider network regardless of sub-delegation or other contractual relationships including but not limited to; complaints, encounter data, utilization management data, financial reports, PCP changes and PCP assignments.

3.10.5.5 Centralized call center receiving all member and provider calls.

3.10.5.6 Single access number to call center.

3.10.5.7 Standard member communication for all members.

3.10.6 Other organization and operations structure requirements as may be established and modified from time to time by CalOptima.

3.11 ENROLLMENT --- Physician shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to Physician.

3.12 PCP ASSIGNMENT --- Physician shall assign Members who have been automatically assigned to Physician by CalOptima to a PCP within seven (7) days of the Member's assignment to Physician.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE ---Physician shall mail to a Member or Member's head of household a notice of enrollment and a Physician Member handbook or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with Physician. All member handbooks and supplements prepared by Physician shall be submitted to CalOptima for approval prior to printing. Physician shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should Physician choose to utilize the CalOptima Member handbook, Physician-specific information on each topic as defined by CalOptima Policies must be included in a CalOptima approved supplement to the CalOptima Member handbook given to all Physicians' CalOptima Members. CalOptima shall provide Physician with a template for the supplement to the CalOptima member handbook.

3.13.2 If Physician chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, Physician's Member handbook shall contain all information included in the CalOptima Member handbook and Physician-specific information on each topic as defined by CalOptima Policies.

3.13.3 Physician shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. Physician shall also provide one (1) copy of its enrollment information including its Physician Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- Physician may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from Physician. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- Physician shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- Physician shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with CCR Title 22, Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Physician shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

3.17.1 Physician and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. Physician shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services in accordance with CalOptima Policies.

3.17.3 It is understood that all Physician, Subcontractors', and Participating Providers' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at Physician, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the Physician, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- Physician and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a

period of not less than ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law, with the exception in which the Physician or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 Physician shall upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18 without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any monitoring, inspection or evaluation is made of the premises of Physician or Subcontractor, Physician shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, Physician shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the Physician's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, Physician shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by Physician and Subcontractors pertaining to these services at any time,, pursuant to 42 CFR section 438.3(h). Records and documents include but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, Physician shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at Physician's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Physician's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of Physician's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Physician, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to Physician. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and Physician will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Physician and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS. Throughout the duration of the Contract and the retention period specified in Section 3.18, Physician and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to Physician's provision of and reimbursement for activities contemplated under the Contract, and to Physician's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports

furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign Physician's statement of confidentiality prior to being admitted access to Physician's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Physician at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Physician from participation in the Medi-Cal program; seek recovery of payments made to the Physician; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, Physician 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 Physician's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Physician asserts that any requested documents are covered by a privilege, Physician shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Physician acknowledges that time may be of the essence in responding to such request. Physician shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Physician or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 Physician further agrees to timely gather, preserve, and provide to DHCS any records in the Physician's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- Physician and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- As identified in Attachment B, Physician shall keep CalOptima informed as to the names of the officers and owners of Physician holding more than five percent (5%) of the stock issued by Physician, and major creditors holding more than five percent (5%) of the debt of Physician and shall notify CalOptima whenever changes occur to the information provided therein.

3.23.1 If provider is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Physician shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its Providers.

3.24 FRAUD AND ABUSE REPORTING --- Physician shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out of Network Providers, Members, or Physician's employees, within two (2) working days of the date when Physician first becomes aware of or is on notice of such activity.

3.24.1 Physician shall notify CalOptima, and CalOptima shall notify DHCS prior to Physician conducting any investigations. Physician shall conduct an investigation after notification has been given.

3.24.2 Physician shall establish, for approval by CalOptima and DHCS, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 Physician shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- Physician shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Physician's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 PHYSICIAN COMPLIANCE PROGRAM --- Physician shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the Physician

annually to ensure that it remains effective. Physician shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM --- Physician and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Physician's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to Physician and Physician shall make them available to Physician's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Physician shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Physician's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and State and/or federal regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- Physician agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. Physician acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOUs) --- Physician agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS --- Physician shall have policies and procedures to verify the Participation Status of Physician's Agents. Physician shall refer to the Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, Physician warrants and agrees as follows:

3.31.1 Physician and Physician's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 Physician shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by Physician or Physician's Agents occurring and/or discovered during the term of this Contract.

3.31.3 Physician shall take immediate action to remove any Physician Agent that does not meet Participation Status requirements from furnishing items or

services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 Physician shall include the obligations of this Section in its Subcontracts.

3.31.5 CalOptima and Physician, as applicable, shall not make payment for a health care item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Physician shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither Physician nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Physician and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 Physician and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance

with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 Physician shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 Physician shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 Physician shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. Physician shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 Physician shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Physician shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. Physician shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. Physician shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, Physician shall provide translation of written member informing materials in the Threshold and Concentration Languages. Physician shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, Physician shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. Physician shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. Physician shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- Physician shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by Physician or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. Physician shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. Physician shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, Physician shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not

feasible, Physician must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. Physician shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's medical record. This documentation shall be available to CalOptima at CalOptima's request. Physician shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. Physician shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- Physician shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. Physician shall make Member Rights available to Member..

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- Physician shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 Physician and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 Physician shall comply with HIPAA requirements as currently established in CalOptima Policies. Physician shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the Physician HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 Physician and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to Physician, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Physician's obligations under this Contract. Physician and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Physician shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Physician from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Physician is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Physician or its Subcontractors, Physician:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Physician by DHCS for this purpose.

3.39 REINSURANCE -- CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance. Physician may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, Physician shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.39.3 In lieu of CalOptima-provided reinsurance, services for CCS Members shall be subject to interim reimbursement for catastrophic cases and retrospective risk corridors, as provided in Attachment E of this Contract.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- Physician shall have a process for claims management and administration. Physician shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. Physician shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE --- Physician shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all CalOptima Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the Physician being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received a MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. Physician shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- Physician acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Physician shall perform all such obligations and duties.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- Physician shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. Physician shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of Physician's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- Physician shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 PHYSICIAN SUBCONTRACTS --- In addition to Section 3.9 of this Contract, Physician shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts.

Physician shall ensure that all Subcontracts are in writing and require that the Physician and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the final date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – Physician understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of Physician under this Contract. In instances where DHCS or CalOptima determines that the Physician or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations to the Physician, (b) require the Physician to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. Physician shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of Physician or the oversight of those obligations.

3.47 Physician acknowledges and agrees that member enrollment combined across Health Networks sharing the same Officer(s), Director(s), General Partner(s) and/or Co-Owner(s), as specified in Attachment B (Disclosure Form) of the Contract, shall not exceed one-third (1/3) of all Members eligible for Health Network enrollment.

ARTICLE 4
Obligations of Physician – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- Physician shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of Physician, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that Physician is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, Physician shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. Physician shall provide Covered Services to Members and Physician agrees as follows:

4.1.1 Physician shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of Physician as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If Physician's network is unable to provide necessary medical services covered under this Contract to a particular Member, Physician must adequately and timely cover these services out of network for the Member, for as long as Physician is unable to provide them. Physician shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 Physician shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating with Physician as to the Medical Necessity of the service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 Physician shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the Physician denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. Physician acknowledges that disputes between the respective Physician and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 Physician may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Physician may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 Physician shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or Physician, CalOptima's or the Physician's insolvency, or breach of this Contract by the Physician or CalOptima, shall Physician or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit Physician or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. Physician or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services, and a copy of such agreement is given to the Member and placed in the Member's Medical Record. Physician further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Physician and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the Physician’s Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the Physician and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 That, in the event of a violation of this Section by Physician or Subcontractor, including, but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against Physician or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- Physician shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 13). Physician is required to provide and pay for all Emergency Services, including Emergency Services

provided by Out of Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 Physician shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if Physician reasonably determines that Emergency Services were never performed.

4.2.2 Not Applicable to this Contract.

4.2.3 Physician shall reimburse those physicians providing services in an Emergency Department with whom Physician has a contract according to the terms of that contract. Physician shall offer to enter into a contract with any physician group contracting with CalOptima for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that CalOptima contract. Physician shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 Physician shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. Physician shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, Physician shall not deny payment for treatment obtained when Physician or a Participating Provider instructs the Member to seek Emergency Services.

4.2.6 Physician shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between Physician or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. Physician may establish relationships with treating facility whereby the Physician may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician agree to accept the transfer of the Member after the Member has been Stabilized.

The attending emergency physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on Physician.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Physician is financially responsible for post-stabilization services obtained within or outside Physician's network that are pre-approved by a plan provider or other entity representative. Physician is financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other Physician representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to Physician for pre-approval of further post-stabilization care services.

4.2.8.1 Physician is also financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if Physician does not respond to a request for pre-approval within 30 minutes; Physician cannot be contacted; or Physician's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, Physician must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 Physician's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Not Applicable to this Contract.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, Physician is financially responsible for payment for post-stabilization services following an emergency admission. Physician shall reimburse those physicians providing post-stabilization services with whom Physician has a contract according to the terms of that contract. Physician shall reimburse all non-contracted physicians providing post-stabilization services in

accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

4.3 NEWBORN SERVICES --- Physician shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- Physician is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Physician shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. Physician's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services, shall not be required.

4.4.1 Physician shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires Physician to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out of Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve Physician from financial responsibility for such services.

4.4.2 Physician shall not prevent Members from receiving Family Planning Covered Services from Out of Network Providers.

4.4.3 Physician shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. Physician shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 Physician shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the Physician has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 Physician shall incorporate specifications of this Section in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- Physician shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH PHYSICIAN OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, Physician shall arrange for the timely referral and coordination of Covered Services to which Physician or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

4.7 ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES. Physician shall ensure the provision of SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network Physician without first requesting a referral from a network Primary Care Physician. Physician shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within Physician's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM --- Physician acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and meeting DHCS access and other requirements. Upon meeting those conditions, CalOptima shall notify Physician of the date upon which Physician will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time Physician shall commence all CalOptima WCM obligations.

ARTICLE 5
Obligations of Physician – Access

5.1 TWENTY-FOUR (24) HOUR PHYSICIAN COVERAGE ---- Physician shall ensure that a physician Participating Provider or physician employed by Physician is available twenty-four (24) hours a day, seven (7) days a week for timely authorization and consultation for Medically Necessary Covered Services, including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, Physician shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies

5.2 URGENT CARE SERVICES --- Physician shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- Physician shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Physician shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Physician's failure to perform at or in excess of minimum performance requirements shall subject Physician to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- Physician shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.5 Not Applicable to this Contract.

5.6 DAYS TO APPOINTMENT---

5.6.1 Non-Emergency Covered Services – Physician shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. Physician shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – Physician shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. Physician shall arrange for the provision of specialty services from specialists outside the network if unavailable within Physician's network, when determined medically necessary.

5.6.3 Preventive Covered Services – Physician shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services – Physician shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. Physician shall cover and ensure the provision of all Medically Necessary services for pregnant Members. Physician shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement – Physician shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
5.6.7.2 Urgent appointment for services that do require prior authorization – within 96 hours of a request;
5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;
5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician for any reason, Physician shall ensure that there is no disruption in services provided to members who are receiving treatment for a chronic or ongoing medical condition or LTSS.

5.7 OFFICE WAITING TIMES --- Physician shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they

may be sanctioned for such non-compliance up to and including termination of their Subcontract. Physician's failure to monitor and enforce Participating Provider office wait time requirements in accordance with the terms of this Contract may subject Physician to sanctions as set forth in this Contract and CalOptima Policies.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- Physician shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialty Physician referrals as set forth in CalOptima's utilization management program. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Physician's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. Physician's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

5.10 NOTICES ABOUT PCP CHANGES --- Physician shall give Members thirty (30) calendar days' notice if their PCP withdraws from Physician. All notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by Physician. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within the Physician for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- Physician shall offer each Member the opportunity to choose a PCP affiliated with the Physician. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When Physician receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, Physician shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment with Physician. Physician shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12 PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, Physician shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, Physician shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1 Primary Care Physicians 1:2,000 Members;
5.13.1.2 Total physicians 1:1,200 Members; and
5.13.1.3 If Non-Physician Medical Practitioners are included in Physician's Network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

5.13.2 Supervising Physicians - Physician shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or
5.13.2.2 Four (4) physician assistants; or
5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- Physician shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- Physician shall make available to every Member, Specialists whose offices are located within fifteen (15) miles or thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). Physician shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles from Member's place of residence.

5.16 PHYSICAL ACCESS --- Physician's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.17 ACCURACY OF PROVIDER DIRECTORY --- Physician shall notify CalOptima within five (5) business days when either of the following occur:

5.17.1 The Provider is not accepting new Members.

5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members

ARTICLE 6
Obligations of Physician – Clinical Quality

6.1 LICENSURE --- Physician shall ensure that every physician providing Covered Services and employed or engaged by Physician or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- Physician shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;
6.2.2 Refer Members to appropriate HEP, based on the Member's needs;
6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,
6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- Physician shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide

only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- Physician shall participate and cooperate in CalOptima's Quality Improvement Program. Physician shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, as well as a semi-annual report to CalOptima's QI department using the Industry Collaboration Effort (ICE) Reporting Tool, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. Physician shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). Physician shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of the Physician or a multi-disciplinary QI Committee designated by the Board of Directors of Physician shall oversee the QI Program conducted by Physician. This committee shall be separate from the Utilization Review committee (though members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from Physician. The QI Committee shall meet at least on a quarterly basis. Physician shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to Physician's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

6.4.6 Physician's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 Physician shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or Physician; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 Physician shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the Physician's QI Program shall be established by the Physician's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify Physician of any additional changes in QI standards and requirements that shall be incorporated in Physician's QI Program. Physician shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 Physician shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, Physician shall provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 Physician shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 Physician shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- Physician shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 Physician shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 Physician Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care, concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review Physician's Case Management Services program to determine compliance with Case Management Services standards. Physician shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 Physician Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, Physician shall assure that Physician possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 OBLIGATION OF PHYSICIAN UPON TERMINATION OF CONTRACTED PROVIDERS --- Physician shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site, and assisting them in selecting a new PCP or PCP site. Physician shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date, and assist them in selecting a new PCP or PCP site. Physician shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. Physician shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or Physician decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with Physician, but the rest of the group continues its contract with Physician, then Physician shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2nd) or third (3rd) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019 or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for

Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, Physician shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by Physician's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Physician shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- Physician shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment. Physician shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. Physician's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions to treat a CCS Eligible Condition. However, Members cannot be limited to a single delegated entity's provider network. Physician must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, Physician may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated Physician shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated Physician shall implement procedures to identify individuals who may need

or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- Physician shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, Physician shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 Physician shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, Physician shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 Physician shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by Physician, Physician remains

responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code, Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), Physician must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, Physician may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, Physician must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Physician's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Physician and the CCS Provider.

6.7.5.2.3 Physician confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or the Provider of Specialized Durable Medical Equipment makes treatment information available to Physician, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, Physician and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, Physician shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Physician shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. Physician shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 Physician shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, Physician shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 Physician shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, Physician shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for

Members receiving continuity of care, Physician shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition Physician for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if Physician denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 Physician must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 CREDENTIALING REQUIREMENTS --- Physician acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to Physician. Physician shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

6.8.1 Physician shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 Physician shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. Physician shall ensure that any Participating Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 Physician shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 Not Applicable to this Contract.

6.9 BOARD CERTIFICATION --- --- Physician shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 Physician shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or

services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 Physician acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations (IPA) and/or other organization or entity that contracts with Physician to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW (FSR/MRR) --- Physician shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. Physician shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- Physician shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 Physician shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the Physician.

6.11.4 Physician shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 Physician shall be responsible for coordinating care of certain services including:

6.11.8.1 Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 Physician shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 Physician shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 Physician shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 Physician shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 Physician shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. Physician shall develop referral and prior authorization policies and procedures to implement the above requirements. Physician shall submit these policies to CalOptima for review and approval;

6.11.8.9 Physician shall provide outpatient mental health services within the PCP's scope of practice. Physician shall refer Members requiring inpatient mental health services to the Orange County Health Care Agency (HCA) Behavioral Health Services. Physician shall retain financial responsibility for initial physical

health assessment for any Member admitted to an inpatient facility. This assessment shall be performed by a facility physician or by the Member's PCP. Physician shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services.

6.11.8.10 Mental Health Services. Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall retain financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU.;

6.11.8.11 For Outpatient Mental Health Services , Physician shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP's scope of practice, Physician shall refer Members to CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, Physician shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

6.11.8.12.1 Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health

psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 Physician shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the Physician is responsible for the coordination of care for Members, CalOptima shall share with Physician, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and Physician shall receive the utilization data provided by CalOptima and use it as the Physician is able for the purpose of Member care coordination.

6.12 VACCINES --- Physicians shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with Physician's immunization policy. CalOptima shall not reimburse Physician for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the CalOptima Approved Drug List and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by CalOptima. The prescribing physician shall be responsible for submitting prior authorization requests and responding to requests for additional information in accordance with regulatory timeframes. The prescribing physician shall provide CalOptima all information necessary to process prior authorization requests.

6.13.1 Physician may be subject to sanctions for Participating Provider's failure to comply with the prior authorization process.

6.13.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.14 RESEARCH --- Physician agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF PHYSICIAN FOR SPD --- Physician shall provide the following for SPD Members:

6.15.1 Physician shall participate in the Community Liaison Program according to the guidelines and policies CalOptima promulgates to operate the program and as set forth in this Contract and CalOptima Policies;

6.15.2 Physician shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 Physician shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. Physician shall not restrict the Incontinence Supplies by brand name as long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 Physician shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) Physician determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD Member's need for the Medical Supplies will remain stable over the six (6) month period.

6.15.5 Physician or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. Physician shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, Physician shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the Physician;

6.15.6 Physician shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. Physician shall provide to all SPD Members upon enrollment with Physician and at any time thereafter, upon the SPD Member's request, a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment with Physician of an SPD Member, Physician shall complete a plan of care pursuant to CalOptima Policies. Physician shall update this plan as appropriate and/or annually. Physician shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies enrolled with Physician, Physician shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 Physician shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 Physician shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

6.15.11 If Physician's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, Physician must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. Physician acknowledges that out-of-network providers must coordinate with Physician with respect to payment, and Physician shall ensure that such out-of-network providers understand this requirement. Physician must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. Physician shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member, in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, Physician shall provide continued access for up to twelve (12) months to an out-of-network provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom they are receiving services), if the provider will accept Physician or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an out-of-network provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, Physician shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 Physician and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS.

6.15.14 Personal Care Coordinator (PCC) Programs for CCS and SPD Members Definitions:

6.15.14.1 "Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members. The Profile shall include the compliance parameters required to receive PCC supplemental capitation.

6.15.14.2 "Individual Care Plan" is a plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

6.15.14.3 "Personal Care Coordinator or PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an CCS Eligible Condition as determined by the local CCS Program, or SPD aid code, supervised by a licensed person, and funded by CalOptima.

6.15.15 Physician shall be eligible to receive the supplemental PCC capitation as defined in Attachment E if Physician remains in good standing with CalOptima which shall include but not limited to the following:

6.15.15.1 No sanctions in place for the Medi-Cal program;
6.15.15.2 Resolution satisfactory to CalOptima of all identified Medi-Cal Program compliance deficiencies from the preceding calendar quarter;
6.15.15.3 Execution of all previous amendments; and
6.15.15.4 Other requirements contained in CalOptima Policy, as applicable.

6.15.16 During any period in which CalOptima provides funding for the PCC program, and written notice that the program is active, Physician shall provide PCC services in accordance with the following:

6.15.16.1 Physician shall employ PCCs and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. Physician shall staff one PCC per six hundred (600) CCS or SPD Members assigned to Physician. PCC responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP. Physician shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence CalOptima Policy requirements.

6.15.16.2 CalOptima shall provide Physician the Profile requirements. Changes to the Profile which may impact PCC supplemental capitation, will be communicated to Physician thirty (30) days prior to the effective date of such change. If Physician is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30)-day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to Physician and termination of the Contract.

6.16 ADVANCE DIRECTIVES --- Physician shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. Physician shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- Physician shall provide, at its sole cost and expense, second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- Physician shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- Physician shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. The Physician shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- Physician shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a

Member's domestic partner, and the domestic partner of the Member's parent or children. Physician shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, Physician and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

ARTICLE 7
Obligations of Physician – Reporting

7.1 DATA REPORTING REQUIREMENTS --- Physician shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. Physician shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- Physician shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies. Physician shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; Physician shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. Physician shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Physician shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon Physician should CalOptima determine that Physician is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- Physician agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that

clearly shows the financial position of Physician as related to Members. Physician shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If Physician is required to file monthly Financial Statements with the DMHC, Physician shall simultaneously file monthly Financial Statements with DHCS. Physician shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Physician shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- Physician shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting Physician's provider network.

7.6 PHYSICIAN ORGANIZATION PROFILE --- Physician shall report in compliance with CalOptima Policies, a profile of the Physician's organization, including, but not limited to, Physician's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- Physician shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by Physician, Physician shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, Physician shall provide copies of any Subcontract entered into or amended for purposes of fulfilling Physician's obligations under this Contract.

7.8 DISCLOSURE --- Physician and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of Physician's or Subcontractor's financial records related to Physician's capacity to bear the risk of potential financial losses, or the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that Physician, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the

meaning of California Civil Code Section 1798.3, Physician shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Physician had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – Physician shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, Physician shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by Physician to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Physician's letterhead signed by the Physician's Chief Executive Office or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of Physician – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that Physician shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Physician at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which Physician received Capitation Payment and termination occurred, Physician shall be paid according to the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Physician shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 Physician agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by Physician.

8.3 TERMINATION PLANS --- Physician shall have a plan for the orderly termination of services under this Contract. Physician shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60 days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- Physician acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and Physician shall notify DHCS of amendments to, or termination of, this Contract . Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Physician acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 Notice to the Department of Managed Health Care. In addition, Physician shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by CalOptima by multiplying the Capitation Rate set forth in Attachment E, by the number of Members enrolled with Physician, by age, gender and Aid Code.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to Physician on or about the fifteenth (15th) of the month for

enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with Physician.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from Physician an amount equal to twenty-five percent (25%) of the monthly Capitation Payment (Withhold). CalOptima may adjust Physician's Capitation Payment on a quarterly basis should the Withhold fall below twenty-five percent (25%) of Physician's current month Capitation Payment. CalOptima may increase this withhold rate in accordance with CalOptima Policy.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the Physician. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Physician as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and Physician shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 OVERPAYMENTS AND CALOPTIMA RIGHT TO RECOVER --- Physician has an obligation to report any overpayment identified by Physician, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Physician, or of receipt of notice of an overpayment identified by CalOptima. Physician acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician, CalOptima shall have the right to recover such amounts from Physician by recoupment or offset from current or future amounts due from CalOptima to Physician, after giving Physician notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Physician to CalOptima, including, but not limited to, amounts due because of:

9.4.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.
9.4.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.
9.4.3 Unpaid Conlan reimbursements owed by Physician to a Member.
9.4.4 Capitation payments made in relation to a Member for a period after the Member was deceased.

9.4.5 In the event that DHCS or CMS establishes a Medicaid Medical Loss Ratio methodology that takes into account sub-capitated providers non-medical costs, amounts recovered from CalOptima by DHCS or CMS for failure to meet such MLR requirements, to the extent attributable to Physician's capitation

9.4.6 Payments made by CalOptima that are the financial responsibility of Physician.

In addition, in the event of termination of the Health Network, or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician paid by CalOptima against any funds owed to Physician by CalOptima, including, but not limited to, capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or Physician additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Physician any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by Physician.

9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Member assigned to Physician is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to Physician is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided

herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- In the event that an adult (age 21+ years) Member assigned to Physician is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY---Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 FINANCIAL SECURITY REQUIREMENTS --- CalOptima shall designate amounts of funds Physician shall establish and maintain as financial security reserves. CalOptima shall identify in CalOptima Policies those financial instruments that shall be acceptable means for purposes of complying with financial security requirements. On a quarterly basis, CalOptima will calculate the minimum required financial security reserves and communicate in writing to the Physician any material deficits.

10.2 COMPREHENSIVE PHYSICIAN AUDIT --- CalOptima shall conduct and Physician shall agree to a full comprehensive compliance audit to be conducted at Physician administrative offices and/or Facilities annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the Physician audit in writing to Physician. Physician may rebut and dispute audit findings pursuant to CalOptima Policies. Physician is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. Physician acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from Physician.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each Physician's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the Physician accurately reported all Encounters.

10.4 APPROVED DRUG LIST --- CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

10.5 REVIEW OF OFF-APPROVED DRUG LIST PRESCRIPTIONS --- CalOptima shall review off-Approved Drug List prescriptions in a timely manner pursuant to CalOptima Policies.

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current MOUs entered into by CalOptima that are binding on Physician. Copies of current MOUs entered into by CalOptima that are binding on Physician may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for Physician interpretation of MOUs entered into by CalOptima that are binding on Physician. Interpretation of MOUs will identify duties, obligation and responsibilities of Physician.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- Physician acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to Physician, information and data relating to the performance of Physician that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Physician, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. Physician complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to Physician the financial risk assumed under the Contract by providing to Physician the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service,

small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Physician, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to Physician the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to Physician sufficient details to allow Physician to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all Physician, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF PHYSICIAN TERMINATION PLANS --- CalOptima shall review and approve Physician termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release Physician's capitation withhold to Physician upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by Physician of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply Physician's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 RELEASE OF FINANCIAL SECURITY REQUIREMENT DEPOSITS --- CalOptima shall release to Physician financial security requirement deposits no less than six (6) months following the termination of this Contract unless termination is the result of Physician insolvency. CalOptima shall release to Physician financial security requirement deposits no less than twelve (12) months following the termination of this Contract if termination is the result of Physician insolvency.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- Physician may contract with out-of-county facilities for Covered Services for CalOptima Members provided that Physician ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

12.2 MEMBER LIAISON PROGRAM (MLP) --- Physician shall establish and maintain support for the Member Liaison Program, including but not limited to:

12.2.1 Providing SPD Members and their caregivers with assistance to navigate the Medi-Cal managed care system;

12.2.2 Coordinating the range of Covered Services needed by SPD Members and assisting SPD Members in understanding and utilizing Physician's referral process;

12.2.3 Ensuring SPD Members receive appropriate and timely referrals;

12.2.4 Identifying barriers faced by SPD Members and integrating recommendations into the delivery system to improve access;

12.2.5 Keeping Physician and Participating Providers educated and sensitive to the needs of persons with disabilities;

12.2.6 Assisting PCPs to fully understand individual SPD Members' needs and provide physicians with access to the many community based resources available;

12.2.7 Providing feedback to CalOptima regarding necessary program modifications/enhancements;

12.2.8 Providing access to SPD Members information necessary for coordination of Covered Services across all Physician departments;

12.2.9 Assisting in the promotion, outreach and community awareness of the MLP.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If Physician fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards, are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Physician's Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements; (xvi) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvii) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xviii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations. CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the Physician or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician or any Subcontractors. CalOptima shall issue a written notice of deficiency and

shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP..

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus the administrative fee from the Physician's Capitation Payment.

13.1.2.2 Physician may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause – Notwithstanding, and in addition to, any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. Physician may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. Physician shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, Physician shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of Physician.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the Physician in the event that Physician's membership falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of Physician's membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should Physician fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should Physician fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to Physician that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should Physician fail to comply with requirements for Physician's organization and operation structure established in this Contract and CalOptima Policies.

13.8 Not Applicable to this Contract.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred twenty (120) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR PHYSICIAN INSOLVENCY --- If Physician becomes insolvent, Physician shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1. In the event of the filing of a petition for bankruptcy by or against Physician or a principal Subcontractor, Physician shall assure that all Physician's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician until Physician fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining

any and all withheld amounts as necessary to ensure that all Physician obligations have been met.

13.11 TERMINATION BY PHYSICIAN FOR CAUSE --- Provided that Physician is not in default hereunder, Physician may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to Physician under this Contract. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to Physician any such past due payments.

13.12 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW--- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contract, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Physician in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Physician shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO PHYSICIAN --- CalOptima may establish key performance measures of Physician to set minimum contract performance thresholds and/or pay financial incentives to Health Networks and Physician groups. CalOptima may take the following actions, at it sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against Physician, terminate this Contract, and establish Capitation Rates and other payments to Physician.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- Physician agrees as follows:

13.14.1 CalOptima reserves the right to require Physician, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members. Imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that Physician Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that Physician terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such

Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks or Physician groups, Physician shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event Physician elects not to participate in any extension period or new contract term.

13.16 Not Applicable to this Contract.

13.17 EXTENSION, RENEWAL, OR MODIFICATION – Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. Physician has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF PHYSICIAN --- CalOptima and Physician agree that Physician and any agents or employees of Physician, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE--- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. Physician shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY --- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

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

14.10 ASSIGNMENT OR DELEGATION ---Physician agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima , as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Physician or Subcontractor; (iii) the merger, reorganization, or consolidation of Physician or Subcontractor with another entity with respect to which Physician or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Physician or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Physician or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of

which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the Physician agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

14.13.1 By signing this Contract, the Physician certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

14.13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

14.13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

14.13.1.6 Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.13.2 If the Physician is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.13.4 If the Physician knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Physician certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION—

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Section 14.16.2.2.

14.16.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment F, entitled "Standard Form-LLL Disclosure of Lobbying Activities") if such recipient has made or has agreed to make any payment using non-appropriated funds to include profits from any covered federal action in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in this

Section of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima
Attention: Director of Contracting
505 City Parkway West
Orange, California 92868
To: Physician

_____
_____
_____
_____

14.18 GOVERNMENT CLAIMS ACT --- Physician shall ensure that Physician and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code sections 900 et seq.), including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

ARTICLE 15
Signatures

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE MARCH 1, 2022 THROUGH JUNE 30, 2022.

IN WITNESS WHEREOF, CalOptima and **Talbert Medical Group, P.C. dba Optum** have executed this Contract:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyun Kim_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer_____
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A- (EFFECTIVE 07/01/2019)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Physician	Hospital Budget	Other
Acupuncture	X		
Allergy Testing & Treatment			
Testing	X		
Serum	X		
Immunotherapy injections	X		
Ambulance	**-See Transportation-**		
Amniocentesis	X		
Anesthesia-for medical diagnosis (Includes Medical, Dental, Mental Health, etc….)			
Professional component	X		
Facility component		X	
Birth Control	**-See Family Planning-**		
Blood and Blood Products			
From blood bank		X	
Transfusions, blood and blood components		X	
Autologous Transfusion (including collection of)		X	
Outpatient Transfusion, Blood and Blood Components		X	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	X		
Facility component		X	
Breast Reconstructive Surgery (after cancer)			
Professional component	X		
Facility component		X	
CBAS			**CalOptima (Claims)**

	Physician	Hospital Budget	Other
CHDP	**-See Pediatric Preventative Services-**		
Chemotherapy			
Professional component	**X**		
Outpatient Facility component		**X**	
Medication	**-See Medication-**		
Chiropractic Services	**X**		
Cosmetic Surgery (Medically Necessary)			
Professional component	**X**		
Facility component (licensed surgical center or acute care facility only)		**X**	
Dental Services			
General dental services-Including teeth			**Denti-Cal**
Oral Maxillofacial Surgery (Repair or accident/injury; medically necessary-Excluding teeth)			
Professional component	**X**		
Facility component		**X**	
Anesthesia Services			
Professional component (Other than provided by Dentist)			
Professional component (Provided by Dentist)			**Denti-Cal**
Facility component			
Detoxification – Medical (inpatient acute medical facility only)			
Professional component	**X**		
Facility component		**X**	
Diagnostic Services, (Outpatient) including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes, (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs, solutions, or other required for the service)			
Professional component	**X**		
Facility component	**X**		
Diagnostic Services (Inpatient), Including Radiology			
Professional component	**X**		
Facility component		**X**	
Dialysis			
Professional component	**X**		
Facility component		**X**	
Durable Medical Equipment (DME) (including insulin pumps)			
Inpatient		**X**	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings, blood glucose meters)	**X**		
Custom Wheelchair Assessment	**X**		

	Physician	Hospital Budget	Other
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		**X**	
Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**		
Facility component, i.e. room use, surgical and medical supplies, injectable medications, infusions and the technical component of diagnostic testing.		**X**	
Mental Health Post Triage / Emergency Stabilization Treatment – admitted to inpatient psychiatric facility			**OC HCA/ State**
EPSDT Supplemental Services			
Acupuncture	**X**		
Autism Screening	**X**		
Audiology	**X**		
Chiropractic	**X**		
Cochlear Implant	**X**		
Dental Services			**State**
EPSDT Case Management	**X**		
Hearing Aid Batteries	**X**		
In-Home Private Duty Nursing (PDN)	**X**		
Medical Nutrition Services	**X**		
Occupational Therapy	**X**		
Orthodontic Services			**Denti-Cal**
Pediatric Day Health Care Services			**State**
Speech Therapy	**X**		
Mental Health – Specialty Outpatient			**OC HCA/ State**
Family Planning (all provider types)			
Professional component	**X**		
Surgically implanted sterilization devices		**X**	
IUDs (with or without medication)	**X**		
Contraceptive items and supplies by a non pharmacy provider (excluding oral, injectable, topical and implantable contraceptive medications)	**X**		
Attachment C contraceptive items/ supplies when provided by CalOptima PBM Pharmacy			**CalOptima (Pharmacy)**
Oral, Implantable, topical and Injectable medications	**-See Medications-**		

	Physician	Hospital Budget	Other
Genetic Disease Screening			
Prenatal Triple Marker Screening			***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening			***DHCS Genetic Disease Branch***
Newborn screening panel		**X**	
Other Genetic Testing/Counseling	**X**		
Hearing Aids	**X**		
Hearing Screening	**X**		
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			**OC HCA / State**
Injectable medications	***-See Medication -***		
Home infusion	***-See Medication -***		
Home Health and Home Infusion Pumps & Supplies		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization – Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided In lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			**OC HCA / State**
Hyperbaric Oxygen Therapy		**X**	
Injectables	***- See Medications -***		
Immunizations	***- See Preventive Services -***		
Laboratory Services			
Inpatient – Medical (technical component)		**X**	
Inpatient – Psychiatric			**OC HCA / State**
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room	***- See Emergency Services -***		
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			**CalOptima (Claims)**
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	

	Physician	Hospital Budget	Other
Outpatient Medical/Surgical Supplies and Dressings			
-- Attachment C Medical Supplies when provided by CalOptima PBM Pharmacy			***CalOptima (Pharmacy)***
All other Medical Supplies1[2]	**X**		
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/ State***
Long Term Care Facility			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by a Pharmacy through CalOptima's PBM.			**Cal Optima (Pharmacy)**
Outpatient Medication dispensed by Non-Pharmacy Providers. Includes physician administered oral and injectable, topical and implantable drugs including chemotherapeutic medication			***CalOptima (Claims)***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products -***		
Psychiatric Medications (Carve-out. See list of medications on the CalOptima website)			**DHCS**
Mental Health			
Behavioral Health Professional Services			
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing			***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit			***OC HCA/ State***
Electroconvulsive Treatment (psychiatrist)			***OC/HCA/ State***
Applied Behavior Analysis (ABA)			***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)		**-In OC- Service is NOT a Medi-Cal Benefit-**	
Behavioral Health Facility			
Acute Care Facility ER not resulting in psych admission			
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit			**OC/HCA/ State**
Patial Hospitalziation Program or Intensive Outpatient PHP, IOP		**-In OC-Service is NOT a Medi-Cal Benefit-**	
Electroconvulsive Treatment Outpatient		**X**	

	Physician	Hospital Budget	Other
Substance Use Disorder (SUD) Professional			
Outpatient-Office-Mild to Mod, Medication Assisted Ttreatment (MAT)-Psychiatrist			**CalOptima (Claims)**
Outpatient-DMC Provider, Intensive Outpatient - DMC Provider			**Drug Medi-Cal**
ER-SUD Consultation			**CalOptima (Claims)**
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**		
Substance Use Disorder (SUD) Facility			
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)		**X**	
Acute Care Facility (Voluntary Inpatient Detox)			**FFS Medi-Cal**
Residential (Detox/Rehab)			**Drug Medi-Cal**
Neuropsych Testing	**X**		
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Products			
Parenteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8, and 9)			***CalOptima (Pharmacy & Claims)***
Enteral Nutrition	**X**		
Enteral Nutrients, Supplies and Pumps (Medicare DMERC Categories 7, 8 and 9)	**X**		
Observation			
Professional component	**X**		
Facility component		**X**	
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	
Occupational Therapy	***- See Rehabilitation -***		
Orthotics	**X**		

	Physician	Hospital Budget	Other
Outpatient Diagnostic Services	***-See Diagnostic Services (Outpatient) -***		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	***- See Medication -***		
Physical Therapy	***- See Rehabilitation -***		
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Preventive Services- Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
Vaccine			***VFC (Vaccines for Children Program)***
Administration fee	**X**		
Prosthetic Devices			
Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		
Radiation Therapy			
Professional component	**X**		
Facility component		**X**	
Radiology Services	***- See Diagnostic Services -***		
Rehabilitation – Physical, Occupational, & Speech Therapy			
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Outpatient professional component	**X**		
Outpatient facility component	**X**		
Long Term Care Facility	**X**		
Skilled Nursing Facility			
Custodial – Long Term Care	***- See Long Term Care Services -***		
Short stay	***- See Hospitalization -***		
Speech Therapy	***- See Rehabilitation -***		
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	**X**		
Facility component		**X**	
Transgender Services			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital Budget	Other
Transplants – Including Procurement			
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)			***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)			***CalOptima (Claims)***
All Other Transplants (e.g. bone graft, cornea, skin)			
Professional component	**X**		
Facility component		**X**	
Transportation (includes ambulance)			
Emergency		**X**	
Non-Emergency Medical Transportation (NEMT)		**X**	
Non-Medical Transportation (NMT)			***CalOptima (Claims)***
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA			***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**		
Vision Care			
Routine adult and child eye refraction examination			***CalOptima (TPA)***
Contact lenses			***CalOptima (TPA)***
Lenses and Frames			***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**		
Intraocular lens – surgically implanted		**X**	
Ophthalmological services	**X**		
Prosthetic eye	**X**		
Whole Child Model-Previously California Children's Services			
Professional component including all Special Care Center services billable on a professional claim	**X**		
Facility component including all Special Care Center services billable on a facility claim		**X**	
Maintenance and Transportation			***CalOptima (Claims)***
Medical Therapy Program			***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.			
[1] ***Incontinence creams and washes are covered per Medi-Cal guidelines***			

ATTACHMENT B

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____

_____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ATTACHMENT C
Formulary Medical Supplies

The following medical supply items are provided through CalOptima's pharmacy network:

	Item	Limitation
Respiratory Items		
	Inhaler Assist Devices	1/Year
	Nasal Aspirator	1/Year
	Peak Flow Meters, Non-Electric	1/Year
Contraceptive Items		
	Condoms	1 Box of 12/Month
	Diaphragms	1/Year
Diabetic Supplies		
	Blood Glucose Monitors	1 Every 3 Years
	Insulin Syringes	100/Month
	Lancets	100/Month
	Lancet Auto Injectors	2/Year
	Blood Glucose Test Strips	100/Month
	Urine Test Strips	100/Month
	Alcohol Pads	200/Month

ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

ATTACHMENT E
Capitation Rates

Effective July 1, 2019

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Family/Poverty/Child	0 year, Both			
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Low Income Children Program (formerly Healthy Families)	0 year, Both			
	01-14 years, Both			
	15-19 years, Female			
	15-19 years, Male			
	20-39 years, Female			
	20-39 years, Male			
	40+ years, Both			
Adult	All Ages Both			
Aged	All Ages, Both			
Disabled	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
ESRD - Family	All ages, Both			
ESRD - Poverty	All ages, Both			
ESRD - Child	All ages, Both			

ESRD - Adult	All ages, Both			
ESRD - Aged	All ages, Both			

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD - Disabled	All ages, Both			
ESRD - MCX	All ages, Both			
ESRD - MSI	All ages, Both			
AIDS - Family	All ages, Both			
AIDS - Poverty	All ages, Both			
AIDS - Child	All ages, Both			
AIDS - Adult	All ages, Both			
AIDS - Aged	All ages, Both			
AIDS - Disabled	All ages, Both			
AIDS - MCX	All ages, Both			
AIDS - MSI	All ages, Both			

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment			

Whole Child Model Base Capitation Rates

The following Whole Child Model payment provisions are effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program.

The following base rates for Whole Child Model are subject to change and the application of risk adjustment and age/gender factors.

	Hospital	Physician	Total Capitation
Whole Child Model			

Interim Reimbursement for Catastrophic Cases. CalOptima shall provide supplemental payments on a quarterly basis to cover costs that exceed the designated thresholds for catastrophic claims, in accordance with CalOptima Policy.

Retrospective Risk Corridor. CalOptima shall, on an annual basis, apply risk corridors to the previous year's CCS-Member-related capitation payments, based on medical costs, and adjust those previous year's capitation payments accordingly, in accordance with CalOptima Policy.

Funding for PCC

In addition to those amounts described above, HMO shall receive ($) per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups. CCS member is identified by their CCS Eligible condition as determined by the local CCS Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Members with a CCS Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E–1

Capitation Rates for Adult Expansion Members

Effective July 1, 2019 through June 30, 2020

Capitation rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future capitation payments to CalOptima, CalOptima will adjust payments made to Physician.

In addition to prospective changes in capitation rates for Adult Expansion Members, DHCS will calculate the MLR for these Members. CalOptima is required to expend at least 85 percent of capitation payments received on Allowed Medical Expenses for Adult Expansion Members. Should CalOptima not meet the minimum 85 percent MLR, CalOptima will be required to return the difference between 85 percent of capitation payments and the allowed medical expenses to the State. CalOptima will require Physician to remit the portion of the difference attributed to Physician.

If CalOptima's MLR exceeds 95 percent of the total capitation payments for the Adult Expansion Members, DHCS shall make additional payment to CalOptima. The additional payment from DHCS to CalOptima will be the difference between the CalOptima's allowed medical expenses and 95 percent of the capitation payments received/ CalOptima will make additional payment as attributed to Physician.

Aid Code	Age & Gender	Base Cap Rate		
Category	Category	Hospital	Physician	Total
Expansion (MCX)	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			
Expansion (MSI)	0 - 14 years, Both			
	15 - 20 years, Female			
	15 - 20 years, Male			
	21 - 44 years, Female			
	21 - 44 years, Male			
	45 + years, Both			

For services rendered to Adult Expansion Members, Physician shall reimburse Specialist Physicians, in the aggregate, at least % of the CalOptima Medi-Cal Fee Schedule. This minimum aggregate reimbursement rate is subject to adjustment by CalOptima in the event that the Capitation Rate in this Attachment F-1 is adjusted in accordance with this Contract.

Supplemental OB Delivery Care Payment (Payment shall be administered per CalOptima policy guidelines).

- Payment rates shall be as follows:

- Physician payment $
- Hospital payment $

Funding for PCC – Effective October 1, 2018

In addition to those amounts described above, HMO shall receive ($) per Medi-Cal CCS or SPD Member per month, to fund the PCC program as authorized by the CalOptima Board of Directors. SPD Member is identified by Aid Code Categories Aged and Disabled, above, for all age groups and CCS member is identified by their CCS Eligible Condition as determined by the local CCS Program. HMO shall only receive PCC funding for a Member with an SPD aid code category or a CCS-eligible condition as determined by the County, not both. Member's with a CCS Eligible Condition shall prevail over SPD members when determining payment.

HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC payments in the event HMO fails to comply with the requirements as defined by the CalOptima Profile and Policy. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Payments in the event CalOptima determines that HMO has not complied with the Profile requirements.

ATTACHMENT E-2

Shared Risk Program

1. Shared Risk Pool. CalOptima and Physician are establishing the Shared Risk Pool as described in this Attachment, which shall be administered by CalOptima and separately accounted for on CalOptima's books. As provided in the previous contract, any Shared Risk Pool deficits remaining at the end of the reconciliation of the final year of the previous contract and any expenses from a previous Shared Risk Period received after the end of that pervious Shared Risk Pool reconciliation period shall be carried forward in the Shared Risk Pool under this Contract. Any deficits remaining at the end of the reconciliation of the final year of this Contract and any late-received expenses for that final year shall similarly be carried forward to any subsequent shared risk contract.

1.1 Shared Risk Services—Definition. Shared Risk Services means all Covered Services that are designated under the caption "Hospital Budget" set forth in Attachment A of this Contract. The amounts or rates that CalOptima will pay to Hospitals for the provision of Shared Risk Services to Members are set forth in the Hospital Services Contract entered into with the participating Hospitals ("Shared Risk Hospital Amount(s)"). Non-Hospital providers of services contained within the "Hospital Budget" shall be paid according to their individual contract rates. Payments made to Hospitals under CalOptima's Health Network carve-out programs, such as the "special tertiary rate" and "high-cost exclusions," shall not be included in Shared Risk Services.

1.2 Shared Risk Budget. In addition to the Hospital Budget Capitation Allocation to the Shared Risk Pool set forth in Section 1 of this Attachment, the Shared Risk Budget shall include the following amounts received by CalOptima or any Hospital in connection with any Shared Risk Services provided to Members: (a) monies recovered from coordination of benefits, and (b) any reinsurance coverage amounts collected or allocated. Shared Risk Costs shall be the actual amounts paid for Shared Risk Services less any recoveries, including, but not limited to, overpayments.

1.3 Shared Risk Expenses. Monthly, during the term of this Contract, the following expenses and charges ("Shared Risk Expenses") shall be deducted from the Shared Risk Budget: (a) the actual Shared Risk Hospital Amounts paid to Hospitals for Shared Risk Services provided to Members, (b) any reinsurance premiums paid by CalOptima that are allocable to the shared risk pool, (c) an estimated amount of IBNR expense (defined below) as reasonably determined by CalOptima (with the final IBNR expense determined in accordance with and as set forth in Section 1.5.1 below), and (d) administrative expenses at a rate of one dollar and sixty cents ($1.60) per Member per month. Any applicable copayments, deductibles or third-party payments collected by CalOptima or Hospitals for Shared Risk Services provided to Members shall be deducted from Shared Risk Expenses.

1.4 Shared Risk Pool – Quarterly Report and Semi-Annual Reconciliation and Adjustment.

1.4.1 Within forty-five (45) days following the end of each calendar quarter during each Shared Risk Period (defined below), CalOptima shall produce a written

report showing all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool during that quarter and the Shared Risk Period to date. Each quarterly Report shall include an estimate of the projected Budget Deficit or Budget Surplus (as such terms are defined in, and as determined consistent with, Section 1.5) determined by annualizing the aggregate amount of the Shared Risk Budget and the Shared Risk Expenses for all months to date in the applicable Shared Risk Period.

1.4.2 Within sixty (60) days of the end of the semi-annual distribution period, which shall be defined as July 1 through December 31 of each Shared Risk Period, CalOptima shall compute the status of the Shared Risk Pool for that semi-annual period as follows: Hospital Budget Allocations made in that semi-annual period minus claims paid for services rendered in that semi-annual period minus a full allocation for Incurred But Not Reported (IBNR) claims based on historical experience with the applicable CalOptima population for that semi-annual period. If the status thus computed shows a surplus, CalOptima shall pay to Physician, from the Hospital Budget Allocation, an amount equal to sixty percent (60%) of such surplus. Any surplus distributions are an advance against the projected final surplus. If the amount is a deficit, it shall be carried forward to the year-end reconciliation.

1.5 Shared Risk Pool -- Year-End Reconciliation and Settlement. The Shared Risk Pool shall be administered on a fiscal-year basis (July 1 through June 30) ("Shared Risk Period").

1.5.1 Within one hundred twenty (120) days following the close of each Shared Risk Period, CalOptima shall audit and reconcile, and produce a written report thereof, all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool. Risk Pool Expenses for any Shared Risk Period identified after the audit, reconciliation and settlement of the Shared Risk Pool for the applicable Shared Risk Period shall be rolled forward to the next succeeding Shared Risk Period. The reconciliation and settlement of the Shared Risk Pool shall take into account incurred but not reported ("IBNR") expenses, regardless of when paid, provided that only those expense items received within (90) days after the end of the current Shared Risk Period shall be included in the computation of the IBNR expense for such Shared Risk Period.

1.5.2 Deficit. If, for any Shared Risk Period, Shared Risk Expenses exceed the Shared Risk Budget (such excess referred to herein as the "Budget Deficit"), an amount equal to sixty percent (60%) of such Budget Deficit, plus the amount of any Semi-Annual distributions, shall be carried forward as a charge against any future distributions under section 1.5.3.

1.5.3 Surplus. If, for any Shared Risk Period, the Shared Risk Budget exceeds the Shared Risk Expenses (such excess referred to herein as the "Budget Surplus"), an amount equal to sixty percent (60%) of such Budget Surplus shall be paid to Physician by CalOptima only after any Semi-Annual distributions have been deducted from the sixty percent (60%) of the Budget Surplus allocable to Physician.

1.5.4 If Physician elects to move from existing contracted shared risk group model to another contract model, Physician's shared risk pool shall not be in deficit.

2. eports and Timely Settlement. CalOptima shall be responsible for maintenance of records and development of reports required for administration of the Shared Risk Pool.

   Physician shall have thirty (30) days following receipt to review annual reports produced by CalOptima under Section 1.5.1 above. Absent reasonable objections in such thirty (30) day period, such annual reports shall be considered final, and any and all payments of Budget Surplus shall be made within fifteen (15) days following the expiration of the 30 day review period.

3. Settlement in the Event of Termination**.** Notwithstanding anything in this Attachment or elsewhere in this Contract, if this Contract is terminated, in accordance with the provisions of Article 13 of this Contract, the Shared Risk Pool shall be settled within one hundred twenty (120) calendar days following the termination of this Contract in accordance with Section 1.5 of this Attachment.

4. Obligations of Physician. Within seventy-two (72) hours following notification of an admission of a Member to any Hospital, Physician shall provide CalOptima with a report in a form acceptable to CalOptima. If, in CalOptima's reasonable opinion, Physician consistently fails to provide such reports to CalOptima, Physician shall be deemed in breach of this Contract, and CalOptima may take all actions permitted under this Contract, including termination of this Contract for cause.

5. Prohibition on Other Agreements with Hospitals. During the term of this Contract, Physician shall not enter into any agreement with any Hospital with respect to the Members assigned to Physician without the prior written approval of CalOptima, and upon any violation of this provision by Physician, this Contract shall be subject to termination pursuant to Section 13.1. of the Contract.

6. IBNR Calculations. For purposes of this Contract, IBNR shall be calculated using Medi-Cal population lag studies to generate completion factors to apply against claims paid to date. If membership is significant enough or if there is a significant change in bed days, as determined by CalOptima, then alternative calculations may be used, separating the combined TANF aid categories from all others, and acute inpatient expenses from all other Hospital Budget expenses. Year-end IBNR will be calculated using claims paid data through ninety (90) days after the end of the Shared Risk Period. The year-end settlement report will note the "claims paid through" date, and subsequent claims paid for that Shared Risk Period will be recorded against the next Shared Risk Period.

7. Termination for Poor Performance. Budget Deficits in two successive Shared Risk Periods shall, at CalOptima's sole discretion, constitute cause for termination under Section 13.1.

ATTACHMENT E-3

DISTRIBUTION OF PROPOSITION 56 FUNDING

This Attachment E-3 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima and Physician shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to physicians for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Physician which Physician agrees to pay to Eligible Contracted Providers who render Qualifying Services (both as defined in this Attachment E-3) effective July 1, 2017 and CalOptima agrees to pay Physician an administrative fee to administer such Prop 56 increase payments as provided in this Attachment E-3.

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment E-3:

    a. "Eligible Contracted Provider" shall mean a Provider who is contracted with Physician to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.

    a. "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.

    b. Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

2. Physician shall administer the Prop 56 increase in accordance with the Addendum for the applicable State fiscal year attached to this Attachment E-3, applicable state and federal requirements and CalOptima policies. Physician shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with the Attachments to this Attachment E-3 in addition to any payment paid by Physician to the Eligible Contracted Provider under their existing contractual arrangements.

3. CalOptima will forward Prop 56 increase payment funding for the initial payments required to be paid by Physician for Qualifying Services furnished by Eligible Contracted Providers for a State fiscal year based on fee-for-service and capitated claims and encounters submitted by Physician, in

accordance with the reports required in Section 5, and accepted by CalOptima. For subsequent payments, once Provider payment is confirmed, based on the monthly reports required by CalOptima in order for it to fulfil state and federal obligations related to the Prop 56 Increase, CalOptima will reimburse Physician for payments made during the prior reporting period. CalOptima will not make payments for clean or accepted encounters for Qualifying Services received by Physician more than one year after the date of service.

4. Physician shall not provide supplemental Prop 56 payments under this Attachment E-3 to any Provider who is not an Eligible Contracted Provider and all such payments shall be for Qualifying Services. Any Proposition 56 funds paid to an ineligible Provider or for non-qualifying services shall constitute an overpayment, which shall be recouped from such Provider by Physician.

5. On a monthly basis, Physician must report to CalOptima, within 15 days of the end of each calendar month, all supplemental Prop 56 payments made pursuant to this Attachment E-3, either directly by Physician or by Physician's delegated entities and subcontractors at Physician's direction. Reports shall include all supplemental Prop 56 payments made during the month. Physician must provide these reports in a format specified by CalOptima, which at a minimum shall include CPT code, service month, payor (i.e. Physician, or delegated entity or subcontractor), and rendering provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

6. CalOptima will pay Physician a two percent (2%) administrative fee (the "Administrative Fee") once CalOptima has confirmed that the required Prop 56 increase payments have been made by Physician to Eligible Contracted Providers based upon the reports required under Section 5 above. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on confirmed Prop 56 increase payments and shall be remitted to the Physician.

7. CalOptima's obligation to pay Physician any Administrative Fees is contingent upon administrative component payments by DHCS to CalOptima for the Prop 56 increase. In no event shall CalOptima be obligated to pay Administrative Fees to Physician if CalOptima has not received funding for administration of the Prop 56 increase from DHCS.

8. Physician shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable. This includes claims payments made effective July 1, 2017 and after.

9. Physician acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 increase payments identifies invalid payments, Physician shall return such Prop 56 increase payments to CalOptima immediately upon notice from CalOptima.

10. Physician agrees to provide to CalOptima promptly, upon request, such data, information and reports as required by CalOptima in order for it to fulfill state and federal obligations related to the Prop 56 Increase.

11. Physician and its subcontractors agree to comply with all applicable Federal and State laws and regulations, contract requirements, CalOptima polices and DHCS guidance, including APLs, Policy Letters, and Plan Letters related to the Prop 56 increase.

12. To ensure proper implementation of the supplemental Prop 56 payments, Physician shall ensure that the requirements of this Attachment E-3 are included in the contracts with its subcontractors responsible for making payments to physicians directly providing services to Members.

13. Physician shall have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a supplemental Prop 56 payments in accordance with contract requirements for other payments. In addition, Physician shall identify a designated point of contact for provider questions and technical assistance.

14. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Physician, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.

ATTACHMENT E-3, ADDENDUM 1

SFY 2017 – 18 (dates of service between July 1, 2017 and June 30, 2018)

Physician shall make the initial payment to Eligible Contracted Providers for dates of service July 1, 2017 through and including April 30, 2018 ("Initial Payment") as reflected on claims submitted to Physician prior to April 30, 2018, no later than July 29, 2018. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-3.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	

ATTACHMENT E-3, ADDENDUM 2

SFY 2018 – 19 (dates of service between July 1, 2018 and June 30, 2019)

Physician shall make the Initial Payment to Eligible Contracted Providers for dates of service July 1, 2018 through and including April 30, 2019, including any adjustments to payments previously made related to services provided during those dates, as reflected on claims submitted to Physician. Payment to Eligible Contracted Providers shall be made based on the codes and amounts in the table below, no later than June 12, 2019. Subsequent payments to Contracted Eligible Providers shall be made by Physician in accordance with the terms of this Attachment E-3, and must be made within 90 calendar days of receiving a clean claim or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by Physician no later than one year after the date of service.

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	
99202	Office/Outpatient Visit New	
99203	Office/Outpatient Visit New	
99204	Office/Outpatient Visit New	
99205	Office/Outpatient Visit New	
99211	Office/Outpatient Visit Est	
99212	Office/Outpatient Visit Est	
99213	Office/Outpatient Visit Est	
99214	Office/Outpatient Visit Est	
99215	Office/Outpatient Visit Est	
90791	Psychiatric Diagnostic Eval	
90792	Psychiatric Diagnostic Eval with medical Services	
90863	Pharmacologic Management.	
99381	Initial Comprehensive Preventive Med E&M (<1-year-old)	
99382	Initial Comprehensive Preventive Med E&M (1-4 Years old	
99383	Initial Comprehensive Preventive Med E&M (5-11 years old)	
99384	Initial Comprehensive Preventive Med E&M (12-17 Years old)	
99385	Initial Comprehensive Preventive Med E&M (18-39 Years old)	
99391	Periodic comprehensive preventive med E&M (<1-year-old)	
99392	Periodic comprehensive preventive med E&M (1-4 years old)	
99393	Periodic comprehensive preventive med E&M (5-11 years old)	
99394	Periodic comprehensive preventive med E&M (12-17 years old)	
99395	Periodic comprehensive preventive med E&M (18-19 years old)	

ATTACHMENT F –1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

ATTACHMENT F – 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

AMENDMENT XVIII TO
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT

THIS AMENDMENT XVIII TO THE MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT ("Amendment") is effective as of **March 1, 2022**, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **ARTA Western California, Inc. dba Optum** ("Physician Group"), with respect to the following facts:

RECITALS

A. Physician Group and CalOptima have entered into a Medicare Advantage Physician Group Service Agreement ("Contract"), whereby Physician Group provides items and services to certain Medicare beneficiaries enrolled in the Medicare Advantage Program operated by CalOptima.

B. CalOptima and Physician Group desire to amend this Contract to update the legal entity name of Physician Group to include a "doing business as" name.

NOW, THEREFORE, the Parties agree as follows:

1. The Parties hereby acknowledge that ARTA Western California, Inc. changed its name to ARTA Western California, Inc. dba Optum. All references to "ARTA Western California, Inc." in the Contract are hereby replaced with "ARTA Western California, Inc. dba Optum".

2. ATTACHMENT I, DISCLOSURE FORM shall be added to the Contract and is attached hereto.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other terms and conditions contained in the Contract shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and Physician Group have executed this Amendment.

For Physician Group:	**For CalOptima:**
Signature	Signature
Print Name	Yunkyung Kim Print Name
Title	Chief Operating Officer Title
Date	Date

ATTACHMENT I

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____

Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

AMENDMENT XXVI TO
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT

THIS AMENDMENT XXVI TO THE MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT ("Amendment") is effective as of **March 1, 2022**, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Monarch HealthCare, A Medical Group, Inc. dba Optum** ("Physician Group), with respect to the following facts:

RECITALS

A. CalOptima and Physician Group (collectively referred herein as "Parties") entered into a Medicare Advantage Physician Group Service Agreement (the "Contract"), by which Physician Group has agreed to provide or arrange for the provision of Covered Services to Enrollees.

B. CalOptima and Physician Group desire to amend this Contract to update the legal entity name of Physician Group to include a "doing business as" name.

NOW, THEREFORE, the Parties agree as follows:

1. The Parties hereby acknowledge that Monarch HealthCare, A Medical Group, Inc. changed its name to Monarch HealthCare, A Medical Group, Inc. dba Optum. All references to "Monarch HealthCare, A Medical Group, Inc." in the Contract are hereby replaced with "Monarch HealthCare, A Medical Group, Inc. dba Optum".

2. ATTACHMENT J, DISCLOSURE FORM shall be added to the Contract and is attached hereto.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other terms and conditions contained in the Contract shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and Physician Group have executed this Amendment.

For Physician Group:	**For CalOptima:**
Signature	Signature
Print Name	Yunkyung Kim Print Name
Title	Chief Operating Officer Title
Date	Date

ATTACHMENT J

DISCLOSURE FORM

_____

Name of Provider

The undersigned hereby certifies that the following information regarding _____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____

Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

AMENDMENT XXVIII TO
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT

THIS AMENDMENT XXVIII TO THE MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICE AGREEMENT ("Amendment") is effective as of **March 1, 2022**, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Talbert Medical Group, P.C. dba Optum** ("Physician Group"), with respect to the following facts:

RECITALS

A. CalOptima and Physician Group (collectively referred herein as "Parties") entered into a Medicare Advantage Physician Group Service Agreement (the "Contract"), whereby Physician Group provides items and services to certain Medicare beneficiaries enrolled in the Medicare Advantage Program operated CalOptima.

B. CalOptima and Physician Group desire to amend this Contract to update the legal entity name of Physician Group to include a "doing business as" name.

NOW, THEREFORE, the Parties agree as follows:

1. The Parties hereby acknowledge that Talbert Medical Group, P.C. changed its name to Talbert Medical Group, P.C. dba Optum. All references to "Talbert Medical Group, P.C." in the Contract are hereby replaced with "Talbert Medical Group, P.C. dba Optum".

2. ATTACHMENT J, DISCLOSURE FORM shall be added to the Contract and is attached hereto.

3. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other terms and conditions contained in the Contract shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and Physician Group have executed this Amendment.

For Physician Group:	**For CalOptima:**
Signature	Signature
Print Name	Yunkyung Kim Print Name
Title	Chief Operating Officer Title
Date	Date

ATTACHMENT J

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated: _____

Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

24. Approve Amendment to Heritage Provider Network, Inc.'s. Medi-Cal Health Network Contract for Health Care Services to Specify Requirements and Responsibilities Related to CalOptima's Enhanced Care Management Services, effective January 1, 2022

Contact

Yunkyung Kim, Chief Operating Officer, 714-246-8408

Recommended Action

Authorize the Chief Executive Officer to amend the Heritage Provider Network, Inc.'s Medi-Cal Health Network Contract for Health Care Services, effective January 1, 2022, to specify requirements and responsibilities related to CalOptima's Enhanced Care Management services for California Advancing and Innovating Medi-Cal.

Background & Discussion

On January 1, 2022, the Department of Health Care Services (DHCS) implemented the 5-year California Advancing and Innovating Medi-Cal (CalAIM) program that takes a whole-person care approach to improving health outcomes for Medi-Cal members, by incorporating both clinical and nonclinical services. A key CalAIM initiative is Enhanced Care Management (ECM), which creates a single, intensive, and comprehensive benefit that is designed to meet the needs of CalOptima's most vulnerable members. ECM services support care coordination with area hospitals as well as primary, dental, behavioral health, specialist, and long-term services and supports (LTSS) providers, administered through members' health networks.

On December 20, 2021, the Board approved amending Heritage Provider Network, Inc. (Heritage) and other health network contracts to:

1. Include the ECM benefit;
2. Revise references to Medi-Cal pharmacy services to support the transition of pharmacy benefits to the DHCS Medi-Cal Rx delivery system; and
3. Align the Corrective Action Plan section of the contracts with current policy.

Heritage representatives and CalOptima staff have further discussed CalAIM roles and responsibilities since the December Board meeting. Although the Board approved the health networks to serve as ECM providers, Heritage has declined to serve as an ECM provider. As a result, and subject to Board approval, Heritage's Medi-Cal contract amendment will specify the obligations of CalOptima Direct when serving as the ECM provider for members who are enrolled in and authorized by Heritage to receive ECM services (except, to the extent applicable, certain Heritage members for whom the County of Orange will serve as an ECM provider per CalOptima policy). Heritage's Medi-Cal contract amendment will also include Heritage's ECM-related responsibilities as the member's health network (such as ECM eligibility determinations, ECM authorization determinations, and communicating new ECM member assignments to the applicable ECM provider), as well as CalOptima's oversight of Heritage's ECM-related responsibilities.

Back to Agenda

Staff therefore requests that the Board authorize amending Heritage's Medi-Cal contract amendment to reflect the requirements and responsibilities for ECM services under CalAIM, effective January 1, 2022, as described above and set forth in detail in Attachment 2 (Proposed Contract Amendment).

Fiscal Impact
The recommended action has no additional fiscal impact.

Rationale for Recommendation
Amending Heritage's Medi-Cal contract to reflect the requirements and responsibilities for ECM services under CalAIM clarifies the responsibilities of both parties regarding administration of the benefit and provision of these services to assigned members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Board Action
2. Proposed Contract Amendment
3. Previous Board Action dated December 20, 2021: *Consider Approving Amendments to all Health Network Medi-Cal Contracts Other than Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C, for Provision of Enhanced Care Management, Transition of Pharmacy Benefits to Medi-Cal Rx and Alignment of the Corrective Action Plan Section of the Contracts with Current Policy*
4. Previous Board Action dated December 3, 2020: *Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business*

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 3, 2020	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business		
October 1, 2020	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend and Amend the Contract to Remove the Medi-Cal Line of Business		
August 6, 2020	Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration		

Back to Agenda

August 1, 2019	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract		
October 4, 2018	Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc. for Pharmacy Benefit Management Services		
May 7, 2015	Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016		

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Heritage Provider Network, Inc.	8510 Balboa Blvd., Ste. 285	Northridge	CA	91325

AMENDMENT XI TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT XI TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of **January 1, 2022,** by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Heritage Provider Network, Inc.** ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to specify requirements, and responsibilities related to CalOptima's Enhanced Care Management (ECM) services for the DHCS California Advancing and Innovating Medi-Cal (CalAIM), revise the Corrective Action Plan section of the Contract and remove Medi-Cal pharmacy services effective with the transition of Pharmacy to DHCS Medi-Cal Rx.

NOW, THEREFORE, the parties agree as follows:

1. Recital C as set forth in the Contract is deleted in its entirety and replaced with the following:

"HMO desires to provide or arrange for the provision of Covered Services to Members as defined herein. Subject to transition requirements, effective no earlier than January 1, 2022, DHCS will transition all administrative services and financial risk related to Medi-Cal pharmacy benefits from CalOptima to DHCS Medi-Cal Rx."

2. Recital E shall be added to the Contract and subsequent Recitals shall be renumbered as appropriate:

"DHCS is adding Enhanced Care Management (ECM) services to the Medi-Cal benefit set, effective January 1, 2022, and transitioning the Whole Person Care (WPC) and the Health Homes Program (HHP) to ECM."

3. Section 1.14, "CalOptima Direct", shall be deleted in its entirety and replaced with the following:

"1.14 "CalOptima Direct" or "COD" means a direct health care program that includes both CalOptima Direct-Administrative (COD-A) and CalOptima Community Network (CCN), which CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or HMO. For purposes of ECM, CalOptima Direct will serve as the ECM Provider for HMO's Members who are authorized by HMO to receive ECM services, except as provided in Section 6.23.5.3 of this Contract".

4. "Section 1.24, "Complex Case Management", shall be deleted in its entirety and replaced with the following:

"1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate

delivery of care and services. Complex Case Management services are provided by the HMO, in collaboration with PCP, and include, at a minimum:

1.24.1 The same services as covered by Basic Case Management;

1.24.2 Management of acute or chronic illness, including emotional and social support issues, by a multidisciplinary case management team;

1.24.3 Intense coordination of resources to ensure the Member regains optimal health or improved functionality;

1.24.4 With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually."

5. The following definitions shall be added to the end of Article 1 "Definitions" of the Contract:

1.106 "Basic Case Management" means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the PCP, or by a PCP-supervised physician assistant, nurse practitioner, or certified nurse midwife, as the medical home. Basic Case Management services are provided by the PCP, in collaboration with HMO, and include:

1.106.1 Initial health assessment;

1.106.2 Individual health education behavioral assessment;

1.106.3 Identification of appropriate Providers and facilities (such as medical, rehabilitation and support services) to meet Member care needs;

1.106.4 Direct communication between the Provider and Member/family;

1.106.5 Member and family education (including healthy lifestyle changes when warranted); and

1.106.6 Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

1.107 "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.108 "ECM Care Team" means a team of staff employed or contracted by CalOptima Direct, as an ECM Provider, that provides ECM services to assigned ECM Members.

1.109 "ECM Member" means a CalOptima Medi-Cal Member who meets inclusion criteria for one of the ECM Populations of Focus, is authorized to receive ECM services, and is enrolled in the HMO.

1.110 "ECM Provider" means CalOptima Direct when providing ECM services to assigned ECM Members pursuant to this Contract.

1.111 "Community Supports means, as set forth in 42 CFR § 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member and must be approved by DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite).

1.112 "Lead Care Manager" means a Member's designated care manager for ECM, who works for or is on staff with the ECM Provider organization. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services."

6. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 1.8, "Approved Drug List", shall be deleted and intentionally left blank.

7. Section 6.23 shall be added as follows:

"6.23 ENHANCED CARE MANAGEMENT ---

6.23.1 CalOptima ECM – HMO, as the Member's Health Network, shall fully cooperate with CalOptima, as the Medi-Cal managed care health plan (MCP) and when serving as an ECM Provider through CalOptima Direct, in the implementation of CalOptima Enhanced Care Management, as required by DHCS, for CalOptima Members enrolled in HMO who meet the DHCS-defined criteria for one of the following Populations of Focus ("ECM Populations of Focus"):

6.23.1.1 Effective January 1, 2022, or such later date as determined by DHCS, for CalOptima Members who meet the DHCS-defined criteria for one of the following: (i) Experiencing homelessness (adults and children/youth); (ii) High utilizer adults; or (iii) adults with serious mental Illness (SMI)/substance use disorder (SUD).

6.23.1.2 Effective January 1, 2023, or such later date as determined by DHCS, for CalOptima Members who meet the DHCS-defined criteria for one of the following: (i) Transitioning from incarceration (adults and children/youth); (ii) Members eligible for Long Term Care (LTC) and at risk of institutionalization; or (iii) Nursing facility residents transitioning to the community.

6.23.1.3 Effective July 1, 2023, or such later date as determined by DHCS, for other CalOptima children and youth who meet the DHCS-defined criteria for one of the following: (i) High utilizer; (ii) Have serious emotional disturbance (SED) or identified to be a clinical high risk CHR) for psychosis; (iii) Enrolled in California Children Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond CCS qualifying condition; or (iv) involved in, or with a history of involvement in, child welfare (including foster care up to age 26).

6.23.2 CalOptima Direct as an ECM Provider – HMO agrees that CalOptima Direct shall be responsible for providing ECM services as the ECM Provider for ECM Members assigned by HMO in accordance with Section 6.23.5 of this Contract. ECM Provider shall ensure its systems and infrastructure are in place to provide ECM services to assigned ECM Members. HMO agrees that the ECM Provider shall implement ECM in compliance with this Contract and CalOptima Policies.

6.23.3 ECM Provider Requirements – HMO agrees that the ECM Provider shall satisfy the ECM Provider requirements as set forth in CalOptima Policies and as follows:

6.23.3.1 ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve and shall have experience and expertise with the services it will provide.

6.23.3.2 ECM Provider shall comply with all applicable State and federal laws and regulations and all ECM requirements in the DHCS-CalOptima ECM and Community Supports Contract and associated guidance.

6.23.3.3 ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

6.23.3.4 ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each Member.

6.23.3.5 ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of an ECM Member care plan that can be shared with other Providers and organizations involved in each ECM Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

6.23.3.6 If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal Provider, pursuant to relevant DHCS APLs including APL 19-004: Provider Credentialing/ Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to the ECM Provider, the ECM Provider shall comply with CalOptima's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

6.23.4 Identifying Members for ECM – HMO, shall proactively identify Members who would benefit from ECM and determine on a case by case basis whether identified Members are eligible for ECM in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

6.23.4.1 HMO agrees that ECM Provider is encouraged to identify Members who would benefit from ECM and send a request to HMO, to determine if the Member is eligible for ECM, consistent with applicable CalOptima Policies.

6.23.5 Member Assignment to ECM Provider

6.23.5.1 HMO shall be responsible for making ECM authorization determinations for its enrolled Members in accordance with applicable CalOptima Policies.

6.23.5.2 HMO agrees that CalOptima Direct shall serve as the ECM Provider for all ECM Members enrolled in the HMO, except as otherwise provided in Section 6.23.5.3 of this Contract.

6.23.5.3 HMO acknowledges and agrees that the County of Orange shall serve as the ECM provider for certain ECM Members as specified in CalOptima Policy GG.1356: Enhanced Care Management Administration. HMO shall fully cooperate and coordinate with CalOptima, as the MCP, and with the County of Orange, serving as the ECM provider for such ECM Members, in accordance with applicable CalOptima Policies and/or as required by CalOptima to ensure compliance with DHCS requirements for ECM.

6.23.5.4 HMO shall communicate new Member assignments as soon as possible to the applicable ECM provider as set forth in Section 6.23.5 of this Contract, but in any event no later than ten (10) business days after ECM authorization.

6.23.5.5 HMO agrees that upon initiation of ECM, the ECM Provider shall ensure each ECM Member assigned to the ECM Provider has a Lead Care Manager who interacts directly with the ECM Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), any Community Supports, and other services that address social determinants of health needs, regardless of setting, as well as Specialty Mental Health Services and/or Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services as applicable (unless the County of Orange is assigned as the ECM provider for the ECM Member).

6.23.5.6 HMO agrees that the ECM Provider shall advise the assigned ECM Member on the process for changing ECM providers, which is permitted at any time, and on the process for switching ECM providers, if requested. HMO agrees that if CalOptima is notified that the ECM Member wishes to change ECM providers, CalOptima, as the MCP, shall implement any requested ECM Provider change within thirty (30) calendar days.

6.23.6 ECM Provider Staffing – HMO agrees that the ECM Provider shall have adequate staff at all times to ensure its ability to carry out responsibilities for each assigned ECM Member consistent with this Contract, CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS-CalOptima ECM and Community Supports Contract and any other related DHCS guidance.

6.23.7 ECM Provider Outreach and Member Engagement – HMO agrees that the ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

6.23.7.1 HMO agrees that the ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate, with the Member's consent, and in compliance with CalOptima Policies. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (i) Mail; (ii) Email; (iii) Texts; (iv) Telephone calls; and (v) Telehealth.

6.23.7.2 HMO agrees that the ECM Provider shall comply with non-discrimination requirements set forth in State and federal law and the State Contract.

6.23.7.3 HMO and ECM Provider will coordinate to ensure that Members who meet exclusionary criteria as defined in CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach do not receive ECM services.

6.23.8. Initiating Delivery of ECM – For purposes of ECM, HMO agrees that the ECM Provider shall obtain, document, and manage assigned Member's authorization for the sharing of personally identifiable information between CalOptima, HMO, and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

6.23.8.1 Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law. HMO agrees that when federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to HMO, and HMO agrees to comply with such Member authorization.

6.23.8.2 HMO agrees that CalOptima, as the MCP, shall discontinue ECM for an assigned ECM Member under the following circumstances: (i) The Member has met their care plan goals for ECM; (ii) The Member is ready to transition to a lower level of care; (iii) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) ECM Provider has not had any contact with the Member despite multiple attempts.

6.23.8.3 HMO agrees that when ECM is discontinued, or will be discontinued for the Member, CalOptima, as the MCP, is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Case Management, Basic Case Management, etc.).

6.23.9 ECM Requirements and Core Service Components of ECM – HMO agrees that the ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost CalOptima Medi-Cal Members enrolled in the HMO and assigned to the ECM Provider. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

6.23.9.1 HMO agrees that if the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth in Section 6.23 of this Contract and CalOptima Policies and that its subcontractors comply with all requirements in DHCS ECM Provider Standard Terms and Conditions and the DHCS-CalOptima ECM and Community Supports Contract.

6.23.9.2 HMO agrees that the ECM Provider shall: (i) Ensure each assigned Member receiving ECM has a Lead Care Manager; and (ii) Coordinate across all sources of care management in the event that an assigned ECM Member is receiving care management from multiple sources. In the event that HMO is informed that an ECM Member is receiving care management or duplication of services from multiple sources HMO agrees to notify CalOptima, as the MCP, to ensure non-duplication of services. To the extent applicable, HMO further agrees to follow CalOptima's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

6.23.9.3 HMO agrees that the ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care for ECM.

6.23.9.4 HMO agrees that the ECM Provider shall provide the following core service components of ECM to each assigned ECM Member in compliance with CalOptima Policies GG.1354: Enhanced Care Management – Eligibility and Outreach and GG.1353: Enhanced Care Management Service Delivery: (i) Outreach and engagement of Members into ECM (ii) Comprehensive assessment and care management plan; (iii) Enhanced coordination of care; (iv) Health promotion; (v) Comprehensive transitional care; (vi) Member and family supports; and (vii) Coordination of and referral to community and social support services.

6.23.9.5 HMO agrees that the ECM Provider shall ensure the establishment of an ECM Care Team and a communication process between Members' ECM Care Team participants related to services being rendered, in accordance with the requirements set forth in CalOptima Policies.

6.23.9.6 HMO agrees that the ECM Provider shall complete a health needs assessment and develop a comprehensive, individualized, person-centered care plan for each assigned ECM Member. ECM Provider shall ensure case conferences are conducted by the ECM Care Team and the ECM Member's health needs assessment and care plan are updated as necessary.

6.23.10 Training – HMO agrees that the ECM Provider shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by CalOptima, including in-person sessions, webinars, and/or calls, as necessary. ECM Provider shall ensure that its staff who will be delivering ECM services complete training required by CalOptima and DHCS prior to participating in the administration of the ECM services.

6.23.11 Data Sharing to Support ECM - HMO and ECM Provider agree to exchange available information and data as required by DHCS guidance and CalOptima Policies, including but not

limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of assigned ECM Members. HMO and ECM Provider shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements (including applying the minimum necessary standard when applicable), and other federal and California state laws and regulations. Further, ECM Provider shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations as necessary. If applicable laws and/or regulations require an ECM Member's valid authorization for release of health information and a legal exception does not apply, ECM Provider may not release such information without the assigned ECM Member's valid authorization.

6.23.11.1 HMO will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable: (i) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider; (ii) Non-duplicative Encounter and/or claims data, as appropriate; (iii) Non-duplicative physical, behavioral, administrative and social determinants of health data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members, as available; and (iv) Reports of performance on quality measures and/or metrics, as requested.

6.23.12 Quality and Oversight –HMO agrees that CalOptima will conduct oversight of ECM Provider's participation in ECM, as well as HMO's ECM-related responsibilities, to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. HMO shall respond to all requests from CalOptima for information and documentation to permit ongoing monitoring of ECM.

6.23.13 ECM Data and Reports. To the extent applicable to HMO's ECM-related responsibilities, HMO shall submit to CalOptima complete, accurate, and timely ECM data and reports in the manner and form acceptable to CalOptima as required by CalOptima Policies or otherwise required by DHCS in order for CalOptima to monitor and meet the following: (i) performance targets; and (ii) its data reporting requirements to DHCS.

6.23.14 ECM Provider's Agent Qualifications – HMO agrees that the ECM Provider shall verify that the qualifications of all agents (including ECM Provider staff) providing ECM services under this Contract comply with the requirements of this Contract, CalOptima Policies, and DHCS guidance. In addition, for agents that enter into Members' homes or have face-to-face interactions with Members, ECM Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. ECM Provider shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract."

8. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 10.4, "Approved Drug List", shall be deleted and intentionally left blank.

9. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 10.5, "Review of Off-Approved Drug Prescriptions", shall be deleted and intentionally left blank.

10. Section 13.1.1 will be deleted in its entirety and replaced with the following:

"13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Subcontractor(s)

is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the HMO or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within fourteen (14) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP."

11. Effective January 1, 2022, or such later date that CalOptima's Medi-Cal Pharmacy Benefits are transitioned to DHCS Medi-Cal Rx, Attachment A – Amendment 8, "CalOptima Medi-Cal Division of Financial Responsibility", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment XI.

12. Attachment C, "Formulary Medical Supplies" shall be deleted from the Contract.

13. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Heritage Provider Network, Inc. have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A – AMENDMENT XI
CalOptima Medi-Cal Division of Financial Responsibility
Effective January 1, 2022

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party				
	Physician		**Hospital**		**Other**
Acupuncture	**X**				
Allergy Testing & Treatment					
Testing	**X**				
Serum	**X**				
Immunotherapy injections	**X**				
Ambulance	***- See Transportation -***				
Amniocentesis	**X**				
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)					
Professional component	**X**				
Facility component			**X**		
Birth Control	***- See Family Planning -***				
Blood and Blood Products					
From blood bank			**X**		
Transfusions, blood and blood components			**X**		
Autologous Transfusion (including collection of)			**X**		
Outpatient Transfusion, Blood and Blood Components			**X**		
Breast Implant (post-mastectomy) or Removal (medically necessary only)					
Professional component	**X**				
Facility component			**X**		
Breast Reconstructive Surgery (after cancer)					
Professional component	**X**				
Facility component			**X**		
CBAS					***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***				
Chemotherapy					
Professional Component	**X**				
Outpatient Facility Component			**X**		
Medication	***- See Medication -***				

	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps and Medi-Cal covered Continuous Glucose Monitors)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies, and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products-***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)					***CalOptima (Claims)***
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy[1]	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies billed by a non-pharmacy provider	**X**				
Condoms, diaphragms and cervical caps when billed by a Pharmacy					***DHCS PBM***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***

	Physician		Hospital		Other
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		

	Physician		Hospital		Other
Outpatient Medical/Surgical Supplies and Dressings					
Disposable Medical Supplies (including Medi-Cal Categories: Enteral, Tracheostomy, Ostomy, Urological, Wound Care, Infusion Tubing) and Supplies billed by a non-Pharmacy Provider	**X**				
Other Disposable Medical Supplies when billed by a Pharmacy					***DHCS PBM***
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***DHCS PBM***
Outpatient Medication billed by a Pharmacy					***DHCS PBM***
Outpatient Medication billed by non-Pharmacy Providers					***CalOptima (Claims)***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC- Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC- Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		

	Physician		Hospital		Other
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Total Parenteral Nutrition (TPN) when provided by Pharmacy					***DHCS PBM***
Total Parenteral Nutrition (TPN) when provided by non-Pharmacy provider					***CalOptima (Claims)***
Total Parenteral Nutrition (TPN) supplies and pumps			**X**		
Enteral Nutrition products included in the DHCS Enteral Nutrition product list					***DHCS PBM***
Enteral Nutrition Supplies and Pumps	**X**				
Other Nutrition Products when not covered by DHCS PBM	**X**				
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***

	Physician		Hospital		Other
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine billed by a non-Pharmacy provider (inclusive of Medi-Cal administration fee)	**X**				
Vaccine billed by a Pharmacy					***DHCS PBM***
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component[1]	**X**				
Outpatient facility component[1]	**X**				
Long Term Care Facility	**X**				

	Physician		Hospital		Other
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				

	Physician		Hospital		Other
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
[1] *Services are the responsibility of MTP if provided under the MTP program.*					
[2] *Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.*					

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

38. Consider Approving Amendments to all Health Network Medi-Cal Contracts Other than Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C, for Provision of Enhanced Care Management, Transition of Pharmacy Benefits to Medi-Cal Rx and Alignment of the Corrective Action Plan Section of the Contracts with Current Policy

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend all health network Medi-Cal contracts other than Kaiser Foundation Health Plan Inc., ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert), for health care services, as follows:

1. Include the Enhanced Care Management benefit, as part of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal initiative;
2. Revise references to Medi-Cal pharmacy services to support the transition of pharmacy benefits to the DHCS Medi-Cal Rx delivery system; and
3. Align the Corrective Action Plan section of the contracts with current policy.

Background

California Advancing and Innovating Medi-Cal / Enhanced Care Management

On January 8, 2021, DHCS released a revised California Advancing and Innovating Medi-Cal (CalAIM) proposal that takes a whole-person care approach to improving health outcomes for Medi-Cal members by incorporating both clinical and nonclinical services. Implementation of CalAIM initiatives by managed care plans spans five years, beginning January 1, 2022. Two key CalAIM initiatives are Enhanced Care Management (ECM) and Community Supports. ECM creates a single, intensive and comprehensive benefit that is designed to meet the needs of CalOptima's most vulnerable members. Community Supports are medically appropriate, cost-effective alternatives that are provided as a substitute for services covered under the California Medicaid State Plan and are delivered by a different provider or in a different setting than those described in the State Plan. ECM and Community Supports are optional for members. CalOptima and delegated health networks will provide ECM services, and the current Whole Person Care (WPC) and Health Homes Program (HHP) providers will deliver Community Supports. For the initial launch of CalAIM and to ensure a smooth transition for WPC and HHP members, CalOptima will offer the following Community Supports currently offered through the County's WPC and CalOptima's HHP:

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

Following the initial January 1, 2022, implementation of ECM and Community Supports, CalOptima will explore expanding the network of providers and Community Supports offerings and will return to this Board for future consideration.

Transition of Pharmacy Benefits to Medi-Cal Rx
In 2020, DHCS announced it would "carve out" the pharmacy benefit from Medi-Cal managed care plans and transition it to the State-administered, fee-for-service "Medi-Cal Rx" delivery system. Health network contracts currently include language that references CalOptima's drug formulary and pharmacy benefit manager (PBM).

Alignment of the Corrective Action Plan Section of the Contracts with Current Policy
CalOptima Policy HH.2005: Corrective Action Plan serves as a guideline for addressing Corrective Action Plans (CAPs) issued by CalOptima's Office of Compliance. Previously, the policy allowed an internal department or First Tier, Downstream, and Related Entities to respond to a CAP within 30 calendar days. As a result of policy updates, this response time has been modified to 14 calendar days.

Discussion

Enhanced Care Management
Starting January 1, 2022, members will receive ECM services through their assigned health network, which will support care coordination with area hospitals as well as primary, dental, behavioral health, specialist, and long term services & supports providers. Health networks are currently providing similar services under HHP. To ensure members' access to ECM services starting January 1, 2022, staff recommend amending all health network Medi-Cal contracts except ARTA, Monarch, and Talbert to reflect the provision of ECM services by CalOptima's Medi-Cal health networks for their assigned members.

Transition of Pharmacy Benefits to Medi-Cal Rx
With DHCS assuming management of Medi-Cal members' pharmacy benefit services through the Medi-Cal Rx delivery system, it is necessary to remove references to CalOptima's drug formulary and PBM from the health network Medi-Cal contracts. Therefore, staff recommend amending the all health network Medi-Cal contracts except ARTA, Monarch, and Talbert to revise references to Medi-Cal pharmacy services to reflect the new DHCS Medi-Cal Rx delivery system.

Alignment of the Corrective Action Plan Section of the Contracts with Current Policy
To ensure that CalOptima's contracts continue to reflect the most current policy, staff recommend approving amendments to all health network Medi-Cal contract amendments except ARTA, Monarch, and Talbert, reflecting the updated CAP response timeframe from 30 calendar days to 14 calendar days.

Fiscal Impact

The recommended action to amend health network Medi-Cal Contracts for Healthcare Services is a budgeted item under the CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021.

CalAIM ECM Services: Management included projected revenues and expenses associated with ECM services in the CalOptima FY 2021-22 Operating Budget, using the best available information at the time. With the addition of this new benefit, utilization associated with eligible Medi-Cal members is difficult to predict. However, staff anticipates forecasted Medi-Cal revenue for the new benefit will be sufficient to cover the anticipated costs through June 30, 2022.

Medi-Cal Rx Carve-out: The CalOptima FY 2021-22 Operating Budget assumed the removal of the pharmacy benefit in the Medi-Cal line of business on January 1, 2022. There is no additional fiscal impact.

CAP Provision: The contract language change is operational in nature and not expected to have any fiscal impact.

Rationale for Recommendation

Approving the health network Medi-Cal contract amendments will ensure access to medically appropriate, cost-effective care for CalOptima's Medi-Cal members and ensure contracts align with Medi-Cal Rx and current policy.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed Health Network Contract Amendment
3. Board Action Dated December 3, 2020: Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business
4. Previous Board Action Dated October 1, 2020: Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract and Remove the Medi-Cal Line of Business
5. CalOptima Policy HH.2005 Corrective Action Plan

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 3, 2020	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business		
October 1, 2020	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend and Amend the Contract to Remove the Medi-Cal Line of Business		
August 6, 2020	Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration		
August 1, 2019	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract		
October 4, 2018	Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc. for Pharmacy Benefit Management Services		
May 7, 2015	Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016		

Michael Hunn *12/15/2021*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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AMENDMENT IX TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT IX TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2022 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to specify requirements, responsibilities, and reimbursement rates related to CalOptima's Enhanced Care Management (ECM) services for the DHCS California Advancing and Innovating Medi-Cal (CalAIM), revise the Corrective Action Plan section of the Contract and remove Medi-Cal pharmacy services effective with the transition of Pharmacy to DHCS Medi-Cal Rx.

NOW, THEREFORE, the parties agree as follows:

1. Recital D as set forth in the Contract is deleted in its entirety and replaced with the following:

   "HMO desires to provide or arrange for the provision of Covered Services to Members as defined herein. Subject to transition requirements, effective no earlier than January 1, 2022, DHCS will transition all administrative services and financial risk related to Medi-Cal pharmacy benefits from CalOptima to DHCS Medi-Cal Rx."

2. Recital E shall be added to the Contract and subsequent Recitals shall be renumbered as appropriate:

   "DHCS is adding Enhanced Care Management (ECM) services to the Medi-Cal benefit set, effective January 1, 2022, and transitioning the Whole Person Care (WPC) and the Health Homes Program (HHP) to ECM."

3. The following definitions shall be added to the end of Article 1 "Definitions" of the Contract:

   "1.106 "Basic Case Management" means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the PCP, or by a PCP-supervised physician assistant, nurse practitioner, or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered Basic Case Management services.

   Basic Case Management Services are provided by the Primary Care Provider, in collaboration with CalOptima, and include:
   - Initial Health Assessment (IHA);
   - Individual Health Education Behavioral Assessment (IHEBA);
   - Identification of appropriate Providers and facilities (such as medical, rehabilitation and support services) to meet Member care needs;
   - Direct communication between the Provider and Member/family;
   - Member and family education, including healthy lifestyle changes when warranted; and

- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

1.107 "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.108 "ECM Care Team" means a team of staff employed or contracted by the HMO, as an ECM Provider, that provides ECM services to ECM Members.

1.109 "ECM Member" means a CalOptima Medi-Cal Member who meets inclusion criteria for one of the ECM Populations of Focus, authorized to receive ECM services, and assigned to the HMO.

1.110 "ECM Provider" means HMO when providing ECM services to ECM Members pursuant to this Contract.

1.111 "Community Supports means, as set forth in 42 CFR § 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member and must be approved by DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite).

1.112 "Lead Care Manager" means a Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services."

4. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 1.8, "Approved Drug List", shall be deleted and intentionally left blank.

5. Section 6.23 shall be added as follows:

"6.23 "ENHANCED CARE MANAGEMENT"

6.23.1 HMO Participation in CalOptima ECM – HMO shall begin participating as an ECM Provider in CalOptima Enhanced Care Management, as set forth below, for CalOptima Members who meet the DHCS-defined criteria for one of the following Populations of Focus ("ECM Populations of Focus"):

6.23.1.1 Effective January 1, 2022, or such later date as determined by DHCS, for CalOptima Members who meet the DHCS-defined criteria for one of the following: (i) Experiencing homelessness (adults and children/youth); (ii) High utilizer adults; or (iii) adults with serious mental Illness (SMI)/substance use disorder (SUD).

6.23.1.2 Effective January 1, 2023, or such later date as determined by DHCS, for CalOptima Members who meet the DHCS-defined criteria for one of the following: (i)

Transitioning from incarceration (adults and children/youth); (ii) Members eligible for Long Term Care (LTC) and at risk of institutionalization; or (iii) Nursing facility residents transitioning to the community.

6.23.1.3 Effective July 1, 2023, or such later date as determined by DHCS, for other CalOptima children and youth who meet the DHCS-defined criteria for one of the following: (i) High utilizer; (ii) Have serious emotional disturbance (SED) or identified to be a clinical high risk CHR) for psychosis; (iii) Enrolled in California Children Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond CCS qualifying condition; or (iv) involved in, or with a history of involvement in, child welfare (including foster care up to age 26).

6.23.2 HMO as an ECM Provider – HMO shall be responsible for providing ECM services as the Member's ECM Provider. ECM Provider shall ensure its systems and infrastructure are in place to provide ECM services to ECM Members. ECM Provider shall implement ECM in compliance with this Contract and CalOptima Policies.

6.23.3 ECM Provider Requirements – HMO, as an ECM Provider, shall satisfy the ECM Provider requirements as set forth in CalOptima Policies and as follows:

6.23.3.1 ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve and shall have experience and expertise with the services it will provide.

6.23.3.2 ECM Provider shall comply with all applicable State and federal laws and regulations and all ECM ~~program~~ requirements in the DHCS-CalOptima ECM and Community Supports Contract and associated guidance.

6.23.3.3 ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

6.23.3.4 ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each Member.

6.23.3.5 ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of an ECM Member care plan that can be shared with other Providers and organizations involved in each ECM Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

6.23.3.6 ECM Provider shall comply with CalOptima's process for vetting the ECM Provider, which may extend to the individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an

ECM Provider. If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal Provider, pursuant to relevant DHCS APLs including APL 19-004: Provider Credentialing/ Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to an ECM Provider, the ECM Provider shall comply with CalOptima's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

6.23.4 Identifying Members for ECM – CalOptima or a Health Network shall proactively identify Members who are eligible for ECM and would benefit from ECM. Members identified by CalOptima shall be communicated to ECM Provider on a monthly basis. For Members identified by the ECM Provider, the ECM Provider shall send a request to CalOptima, to determine if the Member is eligible for ECM, consistent with CalOptima's process for such request, as described in CalOptima Policy GG.1354.

6.23.5 Member Assignment to ECM Provider - CalOptima or Health Network shall communicate new ECM Member assignments to ECM Provider as soon as possible, but in any event no later than ten (10) business days after ECM authorization. ECM Provider shall immediately accept all Members assigned by CalOptima or Health Network for ECM, with the exception that an ECM Provider may decline a Member assignment if ECM Provider is at its pre-determined capacity. ECM Provider shall immediately notify CalOptima or Health Network if it does not have the capacity to accept a Member assignment.

6.23.5.1 Upon initiation of ECM, ECM Provider shall ensure each assigned ECM Member has a Lead Care Manager who interacts directly with the ECM Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health needs, regardless of setting.

6.23.5.2 ECM Provider shall: (i) Advise the ECM Member on the process for changing ECM providers, which is permitted at any time; (ii) Advise the Member on the process for switching ECM providers, if requested; and (iii) Notify CalOptima if the ECM Member wishes to change ECM providers. CalOptima shall implement any requested ECM Provider change within thirty (30) calendar days.

6.23.6 ECM Provider Staffing – At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned ECM Member consistent with this Contract, CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS-CalOptima ECM and Community Supports Contract and any other related DHCS guidance.

6.23.7 ECM Provider Outreach and Member Engagement – ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

6.23.7.1 ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate, with the Member's consent, and in compliance with CalOptima

Policies. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (i) Mail; (ii) Email; (iii) Texts; (iv) Telephone calls; and (v) Telehealth.

6.23.7.2 ECM Provider shall comply with non-discrimination requirements set forth in State and federal law and this Contract.

6.23.7.3 CalOptima and ECM Provider will coordinate to ensure that Members who meet exclusionary criteria as defined in CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach do not receive ECM services.

6.23.8. Initiating Delivery of ECM – ECM Provider shall obtain, document, and manage Member authorization for the sharing of personally identifiable information between CalOptima and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

6.23.8.1 Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to CalOptima.

6.23.8.2 ECM Provider shall notify CalOptima to discontinue ECM under the following circumstances: (i) The Member has met their care plan goals for ECM; (ii) The Member is ready to transition to a lower level of care; (iii) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) ECM Provider has not had any contact with the Member despite multiple attempts.

6.23.8.3 When ECM is discontinued, or will be discontinued for the Member, CalOptima is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Case Management, Basic Case Management, etc.).

6.23.9 ECM Requirements and Core Service Components of ECM – ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members assigned to the HMO. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

6.23.9.1 Subject to all applicable requirements set forth in this Contract (including, but not limited to, subcontracting requirements), if the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth in Section 6.23 of this Contract and CalOptima Policies and that its Subcontractors comply with all requirements in DHCS ECM Provider Standard Terms and Conditions and the DHCS-CalOptima ECM and Community Supports Contract. Notwithstanding any subcontracting arrangements, ECM Provider shall remain responsible and accountable for any subcontracted ECM functions.

6.23.9.2 ECM Provider shall: (i) Ensure each Member receiving ECM has a Lead Care Manager; (ii) Coordinate across all sources of care management in the event that an ECM Member is receiving care management from multiple sources; (iii) Notify CalOptima to

ensure non-duplication of services in the event that an ECM Member is receiving care management or duplication of services from multiple sources; and (iv) Follow CalOptima's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

6.23.9.3 ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care for ECM.

6.23.9.4 ECM Provider shall provide the following core service components of ECM to each assigned ECM Member in compliance with CalOptima Policies GG.1354: Enhanced Care Management – Eligibility and Outreach and GG.1353: Enhanced Care Management Service Delivery: (i) Outreach and engagement of Members into ECM (ii) Comprehensive assessment and care management plan; (iii) Enhanced coordination of care; (iv) Health promotion; (v) Comprehensive transitional care; (vi) Member and family supports; and (vii) Coordination of and referral to community and social support services.

6.23.9.5 ECM Provider shall ensure the establishment of an ECM Care Team and a communication process between Members' ECM Care Team participants related to services being rendered, in accordance with the requirements set forth in CalOptima Policies.

6.23.9.6 ECM Provider shall complete a health needs assessment and develop a comprehensive, individualized, person-centered care plan for each ECM Member. ECM Provider shall ensure case conferences are conducted by the ECM Care Team and the ECM Member's health needs assessment and care plan are updated as necessary.

6.23.10 Training – ECM Provider shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by CalOptima, including in-person sessions, webinars, and/or calls, as necessary. ECM Provider shall ensure that its staff who will be delivering ECM services complete training required by CalOptima and DHCS prior to participating in the administration of the ECM services.

6.23.11 Data Sharing to Support ECM - CalOptima and ECM Provider agree to exchange available information and data as required by DHCS guidance and CalOptima Policies, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of ECM Members. CalOptima and ECM Provider shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements (including applying the minimum necessary standard when applicable), and other federal and California state laws and regulations. Further, ECM Provider shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations as necessary. If applicable laws and/or regulations require an ECM Member's valid authorization for release of health information and a legal exception does not apply, ECM Provider may not release such information without the ECM Member's valid authorization.

6.23.11.1 CalOptima will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable: (i) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider; (ii) Non-duplicative Encounter and/or claims data, as appropriate; (iii) Non-duplicative physical, behavioral,

administrative and social determinants of health data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members, as available; and (iv) Reports of performance on quality measures and/or metrics, as requested.

6.23.12 Claims Submission and Reporting – ECM Provider shall submit claims for the provision of ECM-related services to CalOptima using the national standard specifications and code sets to be defined by DHCS. In the event ECM Provider is unable to submit claims to CalOptima for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to CalOptima with a minimum set of data elements (to be defined by DHCS) necessary for CalOptima to convert the invoice to an encounter for submission to DHCS.

6.23.13 Quality and Oversight – ECM Provider acknowledges that CalOptima will conduct oversight of ECM Provider's participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. ECM Provider shall respond to all requests from CalOptima for information and documentation to permit ongoing monitoring of ECM.

6.23.14 ECM Data and Reports - HMO shall submit to CalOptima complete, accurate, and timely ECM data and reports in the manner and form acceptable to CalOptima as required by CalOptima Policies or otherwise required by DHCS in order for CalOptima to monitor and meet the following: (i) ~~program~~ performance targets; and (ii) its data reporting requirements to DHCS.

6.23.15 ECM Provider's Agent Qualifications - ECM Provider shall verify that the qualifications of all agents (including ECM Provider staff) providing ECM services under this Contract comply with the requirements of this Contract, CalOptima Policies, and DHCS guidance. In addition, for agents that enter into Members' homes or have face-to-face interactions with Members, ECM Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. ECM Provider shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract."

6. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 10.4, "Approved Drug List", shall be deleted and intentionally left blank.

7. Subject to the transition of Medi-Cal pharmacy benefits to DHCS Medi-Cal Rx, Section 10.5, "Review of Off-Approved Drug Prescriptions", shall be deleted and intentionally left blank.

8. Section 13.1.1 will be deleted in its entirety and replaced with the following:

"13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the HMO or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within fourteen (14) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP."

9. Effective January 1, 2022, or such later date that CalOptima's Medi-Cal Pharmacy Benefits are transitioned to DHCS Medi-Cal Rx, Attachment A, "CalOptima Medi-Cal Division of Financial

Responsibility", shall be deleted in its entirety and replaced with the attached Attachment A – Amendment IX.

10. Attachment C, "Formulary Medical Supplies" shall be deleted from the Contract.

11. Attachment E-9, "Funding for ECM Services", shall be added to the Contract and is attached hereto.

12. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A – AMENDMENT IX
CalOptima Medi-Cal Division of Financial Responsibility
Effective January 1, 2022

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	***- See Transportation -***		
Amniocentesis	**X**		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)			
Professional component	**X**		
Facility component		**X**	
Birth Control	***- See Family Planning -***		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***		
Chemotherapy			
Professional Component	**X**		
Outpatient Facility Component		**X**	
Medication	***- See Medication -***		
Chiropractic Services	**X**		

	Physician		Hospital		Other
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps and Medi-Cal covered Continuous Glucose Monitors)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies~~,~~ and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products-***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)					***CalOptima (Claims)***
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy[1]	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component	**X**				
Surgically implanted sterilization devices			**X**		
IUDs (with or without medication)	**X**				
Contraceptive items/supplies billed by a non-pharmacy provider	**X**				
Condoms, diaphragms and cervical caps when billed by a Pharmacy					***DHCS PBM***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				

	Physician	Hospital	Other
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			***OC HCA / State***
Injectable medications	***-See Medication -***		
Home infusion	***-See Medication -***		
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			***OC HCA / State***
Hyperbaric Oxygen Therapy		**X**	
Immunizations	***- See Preventive Services -***		
Laboratory Services			
Inpatient - Medical (technical component)		**X**	
Inpatient – Psychiatric			***OC HCA / State***
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room	***- See Emergency Services -***		
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			***CalOptima (Claims)***
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	
Outpatient Medical/Surgical Supplies and Dressings			
Disposable Medical Supplies (including Medi-Cal Categories: Enteral, Tracheostomy, Ostomy, Urological, Wound Care, Infusion Tubing) and Supplies billed by a non-Pharmacy Provider	**X**		
Other Disposable Medical Supplies when billed by a Pharmacy			***DHCS PBM***
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/State***
Long Term Care Facility			***DHCS PBM***

	Physician		Hospital		Other
Outpatient Medication billed by a Pharmacy					***DHCS PBM***
Outpatient Medication billed by non-Pharmacy Providers					***CalOptima (Claims)***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				

	Physician	Hospital	Other
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**		
Nutritional Products			
Total Parenteral Nutrition (TPN) when provided by Pharmacy			***DHCS PBM***
Total Parenteral Nutrition (TPN) when provided by non-Pharmacy provider			***CalOptima (Claims)***
Total Parenteral Nutrition (TPN) supplies and pumps		**X**	
Enteral Nutrition products included in the DHCS Enteral Nutrition product list			***DHCS PBM***
Enteral Nutrition Supplies and Pumps	**X**		
Other Nutrition Products when not covered by DHCS PBM	**X**		
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	
Occupational Therapy	***- See Rehabilitation -***		
Orthotics	**X**		
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	***- See Medication -***		
Physical Therapy	***- See Rehabilitation -***		
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		

	Physician		Hospital		Other
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine billed by a non-Pharmacy provider (inclusive of Medi-Cal administration fee)	**X**				
Vaccine billed by a Pharmacy					***DHCS PBM***
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component[1]	**X**				
Outpatient facility component[1]	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)	**X**				
Facility component			**X**		
Transgender Services					
Professional component	**X**				
Facility component			**X**		
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***

	Physician		Hospital		Other
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.					
[1] Services are the responsibility of MTP if provided under the MTP program.					
[2] Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.					

Attachment E-9

Funding for Enhanced Care Management (ECM) Services

Effective January 1, 2022, subject to approval by DHCS, CalOptima shall make an ECM Supplemental Payment to HMO for ECM services provided to an ECM Member, in accordance with the terms and conditions of CalOptima Policy FF.4002.

1. ECM Services Supplemental Payment

    1.1 CalOptima shall pay HMO the ECM Supplemental Payment rate of $XXX for each Member who receives three (3) or more hours of ECM services in a given month as identified by twelve (12) or more units, subject to HMO's compliance with all of the following conditions:

    - Member is identified as an ECM-eligible Member as determined by CalOptima based on ECM eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1354;
    - Member is authorized to receive ECM services;
    - Member receives one of the ECM core service components (as set forth in Section 6.23.9.4 of the Contract) in the prior month;
    - The ECM services are billed and reported to CalOptima consistent with CalOptima Policy FF.4002 and DHCS requirements;
    - If applicable, the HMO paid the provider for the ECM services; and
    - The HMO authorized such ECM services.

    1.2 For purposes of this Attachment E-9 only, the term "Per Enrollee Per Month" means an all-inclusive case rate that applies whenever HMO, as the ECM Provider, has provided the minimum level of service payable to an enrolled Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment. HMO shall submit ECM billing data for the ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

2. Upon validation of the ECM billing data and in accordance with CalOptima Policy FF.4002 CalOptima shall pay ninety (90) percent of all clean claims within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all clean claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

3. In addition to Section 9.4 of this Contract, HMO agrees to CalOptima's recovery of any overpayment of ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Provider Network Operations, (657) 900-1116
Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8887

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to remove Medi-Cal PBM services under the contract effective on the date that the Department of Healthcare Services (DHCS) takes over Medi-Cal Managed Care pharmacy benefits, which is expected to be no earlier than April 1, 2021.

Background

As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of a network of contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

Previously, the DHCS announced that it would be "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans (MCPs) and moving it to a fee-for-service program administered at the state level effective January 1, 2021. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. However, on November 16, 2020, DHCS informed MCPs that the implementation date for Medi-Cal Rx would be postponed until April 1, 2021. It is possible that DHCS will extend this implementation deadline in the future.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year term expired on December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. Rather than exercising the second one-year extension option, the parties agreed to a two-year extension, and at the Board's August 1, 2019 meeting, it approved the two-year extension, effective January 1, 2020 through December 31, 2021.

At its October 1, 2020 meeting, the CalOptima Board of Directors authorized an amendment to the agreement with MedImpact to extend the contract for provision of services for the OneCare, OneCare

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Connect and PACE lines of business through December 31, 2024 and to remove the Medi-Cal line of business effective January 1, 2021.

Discussion

Due to the postponement of Medi-Cal Rx, staff are recommending amending CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to remove the Medi-Cal line of business no sooner than April 1, 2021, and to be updated as needed if additional postponements are announced by DHCS.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Consolidated Operating Budget approved by the Board on June 4, 2020, included funding for PBM fees through the end of the fiscal year for the OneCare, OneCare Connect and PACE lines of business.

The FY 2020-21 Consolidated Operating Budget assumed the removal of the Medi-Cal line of business effective January 1, 2021. The fiscal impact to continue administering the pharmacy benefit for the three (3) month period of January through March 2021 results in an expected increase to pharmacy expenses of approximately $151,920,000 (currently unbudgeted), which is comprised of approximately $151 million in pharmacy reimbursement expenses and approximately $920,000 in PBM administrative expenses. Assuming DHCS continues to provide revenue similar to current levels, Staff anticipates such revenue will be sufficient to cover the expenses related to the extension period. In the event that DHCS further extends the Medi-Cal Rx implementation timeline, our working assumption is that it will continue to fund the program at similar levels. Staff will keep the Board apprised of any changes to these assumptions.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for the Medi-Cal line of business through March 31, 2021, and to be revised as needed if additional postponements are announced by DHCS.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract
5. Board Action dated August 6, 2020; Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration
6. Board Action dated October 1, 2020; Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend and Amend the Contract to Remove the Medi-Cal Line of Business
7. DHCS email notification dated November 16, 2020: Medi-Cal Rx Lengthens Transition Time to Full Implementation

/s/ Richard Sanchez — *11/24/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

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CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

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Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

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Catamaran	1,069
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Argus	1,054
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Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration, Inc.

Contact
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

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As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract and Remove the Medi-Cal Line of Business

Contacts

Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to:

1. Remove the Medi-Cal (MC) line of business effective January 1, 2021; and

2. Extend the contract for provision of services for the OneCare, OneCare Connect and PACE lines of business through December 31, 2024.

Background

As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of a network of contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

Effective January 1, 2021, the Department of Health Care Service (DHCS) is "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to a fee-for-service program administered at the state level. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. Therefore, effective January 1, 2021, MedImpact services will include administering pharmacy benefits for CalOptima's OneCare, OneCare Connect and PACE programs only.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year term expired on December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. Rather than exercising the second one year extension option, the parties agreed to a two year extension, and at the Board's August 1, 2019 meeting, it approved the two year extension, effective January 1, 2020 through December 31, 2021.

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Discussion

Because of the complexity of the process and range of services provided, management estimates that a full replacement of CalOptima's PBM system would take over one year to complete, including the RFP process. It would require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives, and the process would need to begin by February 2021 at the latest. Furthermore, with the new Medi-Cal Rx program starting January 1, 2021, pursuing a PBM RFP with a potential PBM transition would cause significant disruptions for CalOptima providers.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.0 stars for 2020.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts annual audits of MedImpact. The purpose of the annual audits is to monitor PBM performance and ensure that CalOptima's pharmacy related obligations are being met satisfactorily for the Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC, CMS and DHCS regulatory requirements. CalOptima's annual audits of the PBM are comprised of two components: offsite and onsite. The offsite portion is performed as a desk review and the onsite portion takes place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate identified deficiencies.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for three years, through December 31, 2024 for the lines of business where CalOptima is responsible for ensuring that members have access to pharmacy services. Staff also recommends, in conjunction with the transfer of Medi-Cal pharmacy benefit management services to the state, to amend the contract to remove the Medi-Cal line of business since this function is being carved out by the state effective January 1, 2021. Staff have worked with MedImpact to develop a transition plan to ensure administrative obligations are met for the Medi-Cal Rx program requirements.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Consolidated Operating Budget approved by the Board on June 4, 2020 includes funding for pharmacy benefit management fees through the end of the fiscal year for the OneCare, OneCare Connect and PACE lines of business. The budget assumes the removal of the Medi-Cal line of business effective January 1, 2021. The recommended action to extend the MedImpact contract through December 31, 2024 is not expected to have any additional fiscal impact in the current fiscal year. Administrative fees paid to MedImpact for the OneCare, OneCare Connect and PACE lines of business will remain the same. Management plans to include funding for pharmacy benefit management fees for the remaining lines of business for the period of July 1, 2022, through December 31, 2024, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional three years, for the period of July 1, 2022, through December 31, 2024 with the elimination of the Medi-Cal line of business based on the DHCS's decision to transition to the Medi-Cal Rx model administered at the state level.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract
5. Board Action dated August 6, 2020; Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

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CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration, Inc.

Contact
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

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As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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From:	Roady, TC
To:	Wood, Michael
Cc:	Frias, Patricia; Gericke, Kristin Pharm.D.
Subject:	FW: DHCS" Nov. 16 Communication to MCP CEOs Regarding Medi-Cal Rx Implementation Delay
Date:	Tuesday, November 17, 2020 10:21:00 AM
Attachments:	image001.png
Importance:	High

FYI, more detailed comm from DHCS to Plan CEOs below on Rx delay

From: Amber Kemp <akemp@calhealthplans.org>
Sent: Tuesday, November 17, 2020 10:06 AM
Subject: DHCS' Nov. 16 Communication to MCP CEOs Regarding Medi-Cal Rx Implementation Delay
Importance: High

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DO NOT CLICK links or attachments unless you are positive the content is safe.

CAHP State Programs Committee (Primary) and Pharmacy Directors:

Please see DHCS' notice below to MCP CEOs related to the Medi-Cal Rx implementation delay.

Thank you,

Amber

Amber Kemp, MBA
Vice President, State Medicaid Policy
California Association of Health Plans
1415 L Street, Suite 850
Sacramento, CA 95814

akemp@calhealthplans.org
Cell: (916) 802-4069
www.calhealthplans.org

From: MMCDPMB (MMCD)@DHCS <MMCDPMB@dhcs.ca.gov>
Sent: Monday, November 16, 2020 3:52 PM
To: scoffin@alamedaalliance.org; Barsam.kasravi@anthem.com; kristen.cerf@blueshieldca.com; Abbie Totten <Abbie.A.Totten@healthnet.com>; richard.sanchez@caloptima.org; ghund@calvivahealth.org; bfreeman@cencalhealth.org; ssonnenshine@ccah-alliance.org; ndiaz@chgsd.com; Sharron.Mackey@cchealth.org; mtatar@goldchp.org; Abbie Totten

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<Abbie.A.Totten@healthnet.com>; MSchrader@hpsj.com; maya.altman@hpsm.org; mcnaughton-j@iehp.org; doug.hayward@khs-net.com; nathaniel.l.oubre@kp.org; kyle.a.murphy@kp.org; jbaackes@lacare.org; Kotal, John <John.Kotal@molinahealthcare.com>; egibboney@partnershiphp.org; PFrias@rchsd.org; jgrgurina@sfhp.org; ctomcala@scfhp.com; kevin_kandalaft@uhc.com; Donna.stidham@aidshealth.org; BrizendineL@aetna.com
Cc: MMCDPMB (MMCD)@DHCS <MMCDPMB@dhcs.ca.gov>; Davis, Kirk@DHCS <Kirk.Davis@dhcs.ca.gov>; Boylan, Autumn@DHCS <Autumn.Boylan@dhcs.ca.gov>; Nau, Nathan@DHCS <Nathan.Nau@dhcs.ca.gov>; Vasquez, Michele@DHCS <Michele.Vasquez@dhcs.ca.gov>; Conde, Stephanie@DHCS <Stephanie.Conde@dhcs.ca.gov>; Tran, Tuyen@DHCS <Tuyen.Tran@dhcs.ca.gov>; Gutierrez, Alex@DHCS <Alex.Gutierrez@dhcs.ca.gov>; Scott, Jennifer@DHCS <Jennifer.Scott@dhcs.ca.gov>; Dutra, Michael@DHCS <Michael.Dutra@dhcs.ca.gov>; Cisneros, Bambi@DHCS <Bambi.Cisneros@dhcs.ca.gov>; Durham, Dana@DHCS <Dana.Durham@dhcs.ca.gov>; Bonnifield, Erica@DHCS <Erica.Bonnifield@dhcs.ca.gov>; Hendrix, Harry@DHCS <Harry.Hendrix@dhcs.ca.gov>
Subject: Medi-Cal Rx Lengthens Transition Time to Full Implementation

Hello Medi-Cal Managed Care Plan (MCP) Partners,

Given the ongoing challenges and constantly evolving health care landscape associated with the unprecedented COVID-19 public health emergency (PHE), the Department of Health Care Services (DHCS), after careful consideration and in close partnership and collaboration with Magellan Medicaid Administration, Inc. (Magellan), has decided to lengthen the transition time for full implementation of Medi-Cal Rx by three (3) months. DHCS and Magellan will continue to dedicate their combined efforts towards Assumption of Operations (AOO) for Medi-Cal Rx on April 1, 2021. In the interim, all current processes and protocols, both effectuated by DHCS and our Medi-Cal managed care plans (MCPs), respectively, should remain unchanged and in place until Medi-Cal Rx launches.

While neither DHCS nor Magellan takes this decision lightly, we are confident that given the COVID-19 PHE, this decision is in the best interests of our Medi-Cal beneficiaries and providers. Lengthening the full implementation will help to ensure a smoother and more complete transition, as well as mitigate potential disruptions to beneficiaries in accessing their medication. Moving the launch of Medi-Cal Rx to April 1, 2021, will provide additional and valuable opportunities for Medi-Cal providers, beneficiaries, MCPs, and other interested parties to become better acclimated to, and familiar with new Medi-Cal Rx policies and processes, through both additional messaging from DHCS and Magellan, as well as additional, targeted stakeholder engagement and outreach efforts.

Please note that DHCS will be updating the Medi-Cal beneficiary notice templates that were planned for release to Medi-Cal fee-for-service beneficiaries on or about December 1, 2020, to include information about the shift in the AOO for Medi-Cal Rx to April 1, 2021. Since our MCP partners are also doing a corresponding 30-day notice to their respective members, DHCS requests that you do not release those notices until you have changed the AOO date to April 1, 2021. Along the same lines, DHCS requests that you modify any outreach campaign materials to also reflect this date change, inclusive of any new Member Identification Cards, Member Handbook/Evidence of Coverage (Errata) changes, etc. Since the shift from AOO on January 1, 2020 to April 1, 2020, is the

only change being made at this time, MCPs do not need to resubmit these materials to DHCS for review and re-approval.

DHCS appreciates your continued support and collaboration relative to this important project, and looks forward to the successful launch and AOO of Medi-Cal Rx on April 1, 2021. If you have any questions about this notification or how it may impact your individual MCP, please feel free to reach out to your DHCS Contract Manager, or direct specific inquiries to the Medi-Cal Rx Project Team at RxCarveOut@dhcs.ca.gov. Thank you.

Sincerely,

The Department of Health Care Services
Medi-Cal Rx Project Team

Department of Health Care Services
MMCDPMB@dhcs.ca.gov | www.dhcs.ca.gov



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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract and Remove the Medi-Cal Line of Business

Contacts

Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to:

1. Remove the Medi-Cal (MC) line of business effective January 1, 2021; and

2. Extend the contract for provision of services for the OneCare, OneCare Connect and PACE lines of business through December 31, 2024.

Background

As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of a network of contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

Effective January 1, 2021, the Department of Health Care Service (DHCS) is "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to a fee-for-service program administered at the state level. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. Therefore, effective January 1, 2021, MedImpact services will include administering pharmacy benefits for CalOptima's OneCare, OneCare Connect and PACE programs only.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year term expired on December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. Rather than exercising the second one year extension option, the parties agreed to a two year extension, and at the Board's August 1, 2019 meeting, it approved the two year extension, effective January 1, 2020 through December 31, 2021.

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Discussion

Because of the complexity of the process and range of services provided, management estimates that a full replacement of CalOptima's PBM system would take over one year to complete, including the RFP process. It would require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives, and the process would need to begin by February 2021 at the latest. Furthermore, with the new Medi-Cal Rx program starting January 1, 2021, pursuing a PBM RFP with a potential PBM transition would cause significant disruptions for CalOptima providers.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.0 stars for 2020.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts annual audits of MedImpact. The purpose of the annual audits is to monitor PBM performance and ensure that CalOptima's pharmacy related obligations are being met satisfactorily for the Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC, CMS and DHCS regulatory requirements. CalOptima's annual audits of the PBM are comprised of two components: offsite and onsite. The offsite portion is performed as a desk review and the onsite portion takes place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate identified deficiencies.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for three years, through December 31, 2024 for the lines of business where CalOptima is responsible for ensuring that members have access to pharmacy services. Staff also recommends, in conjunction with the transfer of Medi-Cal pharmacy benefit management services to the state, to amend the contract to remove the Medi-Cal line of business since this function is being carved out by the state effective January 1, 2021. Staff have worked with MedImpact to develop a transition plan to ensure administrative obligations are met for the Medi-Cal Rx program requirements.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Consolidated Operating Budget approved by the Board on June 4, 2020 includes funding for pharmacy benefit management fees through the end of the fiscal year for the OneCare, OneCare Connect and PACE lines of business. The budget assumes the removal of the Medi-Cal line of business effective January 1, 2021. The recommended action to extend the MedImpact contract through December 31, 2024 is not expected to have any additional fiscal impact in the current fiscal year. Administrative fees paid to MedImpact for the OneCare, OneCare Connect and PACE lines of business will remain the same. Management plans to include funding for pharmacy benefit management fees for the remaining lines of business for the period of July 1, 2022, through December 31, 2024, in future operating budgets.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional three years, for the period of July 1, 2022, through December 31, 2024 with the elimination of the Medi-Cal line of business based on the DHCS's decision to transition to the Medi-Cal Rx model administered at the state level.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract
5. Board Action dated August 6, 2020; Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

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Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

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CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
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Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
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Catamaran	1,069
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Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration, Inc.

Contact
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

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As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Richard Sanchez 12/07/2020*
Effective Date:	11/01/1998
Revised Date:	12/03/2020

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

b. Steps taken to resolve the deficiency;

c. Steps taken to avoid reoccurrence;

d. Method for implementation and completion of ICAP response or CAP response;

e. Individual(s) responsible for implementation of the ICAP response or CAP response;

f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

a. A summary of previous outreach and required action(s);

b. An explanation of why that the resolution was not acceptable, or why a response was not received;

c. A revised response timeline of two (2) business days for an ICAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

d. A revised response timeline of five (5) business days for a CAP;

i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance issues an ICAP request with respect to the CalOptima Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager for Medi-Cal within three (3) business days of issuance.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9

J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in the AOC charter.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. Downstream Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,**500)** during a contract period.

Term	Definition
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Provider Network Operations, (657) 900-1116
Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8887

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to remove Medi-Cal PBM services under the contract effective on the date that the Department of Healthcare Services (DHCS) takes over Medi-Cal Managed Care pharmacy benefits, which is expected to be no earlier than April 1, 2021.

Background

As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of a network of contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

Previously, the DHCS announced that it would be "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans (MCPs) and moving it to a fee-for-service program administered at the state level effective January 1, 2021. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. However, on November 16, 2020, DHCS informed MCPs that the implementation date for Medi-Cal Rx would be postponed until April 1, 2021. It is possible that DHCS will extend this implementation deadline in the future.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year term expired on December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. Rather than exercising the second one-year extension option, the parties agreed to a two-year extension, and at the Board's August 1, 2019 meeting, it approved the two-year extension, effective January 1, 2020 through December 31, 2021.

At its October 1, 2020 meeting, the CalOptima Board of Directors authorized an amendment to the agreement with MedImpact to extend the contract for provision of services for the OneCare, OneCare

Connect and PACE lines of business through December 31, 2024 and to remove the Medi-Cal line of business effective January 1, 2021.

Discussion

Due to the postponement of Medi-Cal Rx, staff are recommending amending CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to remove the Medi-Cal line of business no sooner than April 1, 2021, and to be updated as needed if additional postponements are announced by DHCS.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Consolidated Operating Budget approved by the Board on June 4, 2020, included funding for PBM fees through the end of the fiscal year for the OneCare, OneCare Connect and PACE lines of business.

The FY 2020-21 Consolidated Operating Budget assumed the removal of the Medi-Cal line of business effective January 1, 2021. The fiscal impact to continue administering the pharmacy benefit for the three (3) month period of January through March 2021 results in an expected increase to pharmacy expenses of approximately $151,920,000 (currently unbudgeted), which is comprised of approximately $151 million in pharmacy reimbursement expenses and approximately $920,000 in PBM administrative expenses. Assuming DHCS continues to provide revenue similar to current levels, Staff anticipates such revenue will be sufficient to cover the expenses related to the extension period. In the event that DHCS further extends the Medi-Cal Rx implementation timeline, our working assumption is that it will continue to fund the program at similar levels. Staff will keep the Board apprised of any changes to these assumptions.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for the Medi-Cal line of business through March 31, 2021, and to be revised as needed if additional postponements are announced by DHCS.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract
5. Board Action dated August 6, 2020; Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration
6. Board Action dated October 1, 2020; Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend and Amend the Contract to Remove the Medi-Cal Line of Business
7. DHCS email notification dated November 16, 2020: Medi-Cal Rx Lengthens Transition Time to Full Implementation

/s/ Richard Sanchez *11/24/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

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CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
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Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration, Inc.

Contact
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

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As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract and Remove the Medi-Cal Line of Business

Contacts

Emily Fonda, M.D., Deputy Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's Pharmacy Benefits Manager (PBM) services agreement with MedImpact Healthcare Systems Inc. (MedImpact) to:

1. Remove the Medi-Cal (MC) line of business effective January 1, 2021; and

2. Extend the contract for provision of services for the OneCare, OneCare Connect and PACE lines of business through December 31, 2024.

Background

As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of a network of contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

Effective January 1, 2021, the Department of Health Care Service (DHCS) is "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and moving it to a fee-for-service program administered at the state level. "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system. Therefore, effective January 1, 2021, MedImpact services will include administering pharmacy benefits for CalOptima's OneCare, OneCare Connect and PACE programs only.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year term expired on December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. Rather than exercising the second one year extension option, the parties agreed to a two year extension, and at the Board's August 1, 2019 meeting, it approved the two year extension, effective January 1, 2020 through December 31, 2021.

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Discussion

Because of the complexity of the process and range of services provided, management estimates that a full replacement of CalOptima's PBM system would take over one year to complete, including the RFP process. It would require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives, and the process would need to begin by February 2021 at the latest. Furthermore, with the new Medi-Cal Rx program starting January 1, 2021, pursuing a PBM RFP with a potential PBM transition would cause significant disruptions for CalOptima providers.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.0 stars for 2020.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts annual audits of MedImpact. The purpose of the annual audits is to monitor PBM performance and ensure that CalOptima's pharmacy related obligations are being met satisfactorily for the Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC, CMS and DHCS regulatory requirements. CalOptima's annual audits of the PBM are comprised of two components: offsite and onsite. The offsite portion is performed as a desk review and the onsite portion takes place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate identified deficiencies.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for three years, through December 31, 2024 for the lines of business where CalOptima is responsible for ensuring that members have access to pharmacy services. Staff also recommends, in conjunction with the transfer of Medi-Cal pharmacy benefit management services to the state, to amend the contract to remove the Medi-Cal line of business since this function is being carved out by the state effective January 1, 2021. Staff have worked with MedImpact to develop a transition plan to ensure administrative obligations are met for the Medi-Cal Rx program requirements.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2020-21 Consolidated Operating Budget approved by the Board on June 4, 2020 includes funding for pharmacy benefit management fees through the end of the fiscal year for the OneCare, OneCare Connect and PACE lines of business. The budget assumes the removal of the Medi-Cal line of business effective January 1, 2021. The recommended action to extend the MedImpact contract through December 31, 2024 is not expected to have any additional fiscal impact in the current fiscal year. Administrative fees paid to MedImpact for the OneCare, OneCare Connect and PACE lines of business will remain the same. Management plans to include funding for pharmacy benefit management fees for the remaining lines of business for the period of July 1, 2022, through December 31, 2024, in future operating budgets.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional three years, for the period of July 1, 2022, through December 31, 2024 with the elimination of the Medi-Cal line of business based on the DHCS's decision to transition to the Medi-Cal Rx model administered at the state level.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services
4. Board Action dated August 1, 2019, Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract
5. Board Action dated August 6, 2020; Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration

/s/ Richard Sanchez — *09/23/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action
Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion
At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

Contact
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize CalOptima's Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for two years, effective January 1, 2020 through December 31, 2021.

Background
As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services.

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The MedImpact agreement allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. The first extension option was exercised by staff, and at the October 4, 2018 meeting, the CalOptima Board of Directors ratified this extension of the MedImpact agreement effective January 1, 2019 through December 31, 2019. A single one-year extension option remains, and the contract requires CalOptima to provide ninety-day prior written notice to MedImpact in order to exercise the option.

Discussion
A full replacement of the PBM system would take over a year to complete, including a Request for Proposal (RFP) process. It would also require a dedicated team from several departments within CalOptima at a time with multiple competing resource-intensive initiatives.

MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual DHCS audit, as well as CMS Part D data validation audits. Furthermore, MedImpact contributes to the OneCare Part D star rating, which achieved 4.5 stars for 2019.

In addition, CalOptima's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and assure that CalOptima functions are being performed satisfactorily for Medi-Cal, OneCare and OneCare Connect lines of business. MedImpact is evaluated based upon CalOptima requirements, NCQA accreditation standards, DMHC,

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CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review and the onsite portion took place at the MedImpact location. From the 2018 annual audit, MedImpact performed satisfactorily and is working cooperatively with A&O to remediate any deficiencies identified.

Staff have been satisfied with MedImpact's performance to date, and audit results are favorable. Based on these factors, Management is recommending that the Board authorize extension of the current contract with MedImpact for two years, through December 31, 2021. While this is one year beyond what was originally included, the recommended approach would allow sufficient time to complete an RFP process.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2019-20 Consolidated Operating Budget approved by the Board on June 6, 2019, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to extend the contract through December 31, 2021, is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2020, through December 31, 2021, in future operating budgets.

Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional two years.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
3. Board Action dated At the October 4, 2018, Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

/s/ Michael Schrader *7/24/19*

Authorized Signature **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Management Services

Contact

Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400
Kristin Gericke, Director, Clinical Pharmacy Management, (714) 246-8400

Recommended Action

Ratify extension of CalOptima's current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for one year, effective January 1, 2019 through December 31, 2019.

Background/Discussion

At its May 7, 2015 meeting, the CalOptima Board of Directors authorized an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. As CalOptima's PBM, MedImpact provides certain administrative services, including maintenance of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, credentialing and other services. The initial three-year PBM Services Agreement with MedImpact expires December 31, 2018.

Per the terms of the contract, CalOptima is required to provide ninety-day prior written notice to MedImpact in order to exercise each extension option. Based on MedImpact's performance to date in working with CalOptima staff and fulfilling its obligations to Members, Staff has provided MedImpact with notice exercising the first one-year extension option, extending the agreement through December 31, 2019. Staff requests Board ratification of this extension. Staff is separately negotiating additional changes to the CalOptima-MedImpact agreement (e.g., related to the MegaReg), and will return to the Board with further recommendations on a contract amendment at a future meeting.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2018-19 Consolidated Operating Budget approved by the Board on June 7, 2018, includes funding for pharmacy benefit management fees through the end of the fiscal year. Assuming continuance of the terms of the current PBM contract, the recommended action to ratify extension of the contract through December 31, 2019 is not expected to have any additional fiscal impact in the current fiscal year. Management plans to include funding for the period of July 1, 2019 through December 31, 2019, in the CalOptima FY 2019-20 Operating Budget.

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Rationale for Recommendation

The proposed approach allows CalOptima to continue the current PBM Services Agreement for an additional year.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entity Covered by This Recommended Board Action
2. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

/s/ Michael Schrader — **Authorized Signature**

9/26/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact
Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

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Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs' operations.

At the Board's April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders' capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact's proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact
The annual cost of the contract will be approximately $6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between $1 and $1.5 million annually.

Rationale for Recommendation
CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration, Inc.

Contact
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

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As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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From:	Roady, TC
To:	Wood, Michael
Cc:	Frias, Patricia; Gericke, Kristin Pharm.D.
Subject:	FW: DHCS" Nov. 16 Communication to MCP CEOs Regarding Medi-Cal Rx Implementation Delay
Date:	Tuesday, November 17, 2020 10:21:00 AM
Attachments:	image001.png
Importance:	High

FYI, more detailed comm from DHCS to Plan CEOs below on Rx delay

From: Amber Kemp <akemp@calhealthplans.org>
Sent: Tuesday, November 17, 2020 10:06 AM
Subject: DHCS' Nov. 16 Communication to MCP CEOs Regarding Medi-Cal Rx Implementation Delay
Importance: High

WARNING: This email originated outside of CalOptima. Even if this looks like a CalOptima email, it is not.
DO NOT provide your username, password, or any other personal information in response to this or any other email.
CALOPTIMA WILL NEVER ask you for your username or password via email.
DO NOT CLICK links or attachments unless you are positive the content is safe.

CAHP State Programs Committee (Primary) and Pharmacy Directors:

Please see DHCS' notice below to MCP CEOs related to the Medi-Cal Rx implementation delay.

Thank you,

Amber

Amber Kemp, MBA
Vice President, State Medicaid Policy
California Association of Health Plans
1415 L Street, Suite 850
Sacramento, CA 95814

akemp@calhealthplans.org
Cell: (916) 802-4069
www.calhealthplans.org

From: MMCDPMB (MMCD)@DHCS <MMCDPMB@dhcs.ca.gov>
Sent: Monday, November 16, 2020 3:52 PM
To: scoffin@alamedaalliance.org; Barsam.kasravi@anthem.com; kristen.cerf@blueshieldca.com; Abbie Totten <Abbie.A.Totten@healthnet.com>; richard.sanchez@caloptima.org; ghund@calvivahealth.org; bfreeman@cencalhealth.org; ssonnenshine@ccah-alliance.org; ndiaz@chgsd.com; Sharron.Mackey@cchealth.org; mtatar@goldchp.org; Abbie Totten

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<Abbie.A.Totten@healthnet.com>; MSchrader@hpsj.com; maya.altman@hpsm.org; mcnaughton-j@iehp.org; doug.hayward@khs-net.com; nathaniel.l.oubre@kp.org; kyle.a.murphy@kp.org; jbaackes@lacare.org; Kotal, John <John.Kotal@molinahealthcare.com>; egibboney@partnershiphp.org; PFrias@rchsd.org; jgrgurina@sfhp.org; ctomcala@scfhp.com; kevin_kandalaft@uhc.com; Donna.stidham@aidshealth.org; BrizendineL@aetna.com
Cc: MMCDPMB (MMCD)@DHCS <MMCDPMB@dhcs.ca.gov>; Davis, Kirk@DHCS <Kirk.Davis@dhcs.ca.gov>; Boylan, Autumn@DHCS <Autumn.Boylan@dhcs.ca.gov>; Nau, Nathan@DHCS <Nathan.Nau@dhcs.ca.gov>; Vasquez, Michele@DHCS <Michele.Vasquez@dhcs.ca.gov>; Conde, Stephanie@DHCS <Stephanie.Conde@dhcs.ca.gov>; Tran, Tuyen@DHCS <Tuyen.Tran@dhcs.ca.gov>; Gutierrez, Alex@DHCS <Alex.Gutierrez@dhcs.ca.gov>; Scott, Jennifer@DHCS <Jennifer.Scott@dhcs.ca.gov>; Dutra, Michael@DHCS <Michael.Dutra@dhcs.ca.gov>; Cisneros, Bambi@DHCS <Bambi.Cisneros@dhcs.ca.gov>; Durham, Dana@DHCS <Dana.Durham@dhcs.ca.gov>; Bonnifield, Erica@DHCS <Erica.Bonnifield@dhcs.ca.gov>; Hendrix, Harry@DHCS <Harry.Hendrix@dhcs.ca.gov>
Subject: Medi-Cal Rx Lengthens Transition Time to Full Implementation

Hello Medi-Cal Managed Care Plan (MCP) Partners,

Given the ongoing challenges and constantly evolving health care landscape associated with the unprecedented COVID-19 public health emergency (PHE), the Department of Health Care Services (DHCS), after careful consideration and in close partnership and collaboration with Magellan Medicaid Administration, Inc. (Magellan), has decided to lengthen the transition time for full implementation of Medi-Cal Rx by three (3) months. DHCS and Magellan will continue to dedicate their combined efforts towards Assumption of Operations (AOO) for Medi-Cal Rx on April 1, 2021. In the interim, all current processes and protocols, both effectuated by DHCS and our Medi-Cal managed care plans (MCPs), respectively, should remain unchanged and in place until Medi-Cal Rx launches.

While neither DHCS nor Magellan takes this decision lightly, we are confident that given the COVID-19 PHE, this decision is in the best interests of our Medi-Cal beneficiaries and providers. Lengthening the full implementation will help to ensure a smoother and more complete transition, as well as mitigate potential disruptions to beneficiaries in accessing their medication. Moving the launch of Medi-Cal Rx to April 1, 2021, will provide additional and valuable opportunities for Medi-Cal providers, beneficiaries, MCPs, and other interested parties to become better acclimated to, and familiar with new Medi-Cal Rx policies and processes, through both additional messaging from DHCS and Magellan, as well as additional, targeted stakeholder engagement and outreach efforts.

Please note that DHCS will be updating the Medi-Cal beneficiary notice templates that were planned for release to Medi-Cal fee-for-service beneficiaries on or about December 1, 2020, to include information about the shift in the AOO for Medi-Cal Rx to April 1, 2021. Since our MCP partners are also doing a corresponding 30-day notice to their respective members, DHCS requests that you do not release those notices until you have changed the AOO date to April 1, 2021. Along the same lines, DHCS requests that you modify any outreach campaign materials to also reflect this date change, inclusive of any new Member Identification Cards, Member Handbook/Evidence of Coverage (Errata) changes, etc. Since the shift from AOO on January 1, 2020 to April 1, 2020, is the

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only change being made at this time, MCPs do not need to resubmit these materials to DHCS for review and re-approval.

DHCS appreciates your continued support and collaboration relative to this important project, and looks forward to the successful launch and AOO of Medi-Cal Rx on April 1, 2021. If you have any questions about this notification or how it may impact your individual MCP, please feel free to reach out to your DHCS Contract Manager, or direct specific inquiries to the Medi-Cal Rx Project Team at RxCarveOut@dhcs.ca.gov. Thank you.

Sincerely,

The Department of Health Care Services
Medi-Cal Rx Project Team

Department of Health Care Services
MMCDPMB@dhcs.ca.gov | www.dhcs.ca.gov



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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

25. Adopt Resolutions to Authorize the Appointment of Retired Annuitants to the Positions of Interim Chief Medical Officer and Medical Director to carry out the duties and responsibilities of the vacant positions during a public health emergency to mitigate the effects of the COVID-19 pandemic and prevent the stoppage of public business

Contacts

Michael Hunn, Interim Chief Executive Officer, 657-900-1481
Brigette Hoey, Executive Director, Human Resources, (714) 246-8405

Recommended Actions

1. Adopt Resolution No. 22-0203-02 continued appointment of a CalPERS retired annuitant in accordance with Government Code section 21221, subdivision (h) and Executive Order N-84-20 during a public health emergency to mitigate the effects of the COVID-19 pandemic, and certifying the nature of the employment of Dr. Donald Sharps.
2. Authorize the CEO to continue to appoint Dr. Donald Sharps as an interim appointment retired annuitant to the vacant position of Medical Director beyond the work hour limitations as permitted by Executive Order N-84-20.
3. Adopt Resolution No. 22-0203-03 authorizing the hiring of a CalPERS retired annuitant in accordance with Government Code section 21222, subdivision (h) and pursuant to Executive Order N-84-20 to the position of Interim Chief Medical Officer during a public health emergency to mitigate the effects of the COVID-19 pandemic, reappointment to the position of Medical Director thereafter during a public health emergency to mitigate the effects of the COVID-19 pandemic, and certifying the nature of the employment of Dr. Richard Helmer.
4. Authorize the CEO to approve and appoint Dr. Richard Helmer as an interim appointment retired annuitant to the vacant position of Interim Chief Medical Officer from December 22, 2021, to February 6, 2022, and reappoint Dr. Richard Helmer as an interim appointment and retired annuitant to the vacant position of Medical Director effective February 7, 2022.
5. Authorize the CEO, or his designee, to continue the current search for permanent Medical Directors.

Background/Discussion

A retired annuitant is a CalPERS retiree who works as an at-will employee for a CalPERS employer with certain restrictions to avoid jeopardizing his or her retirement allowance (pension payments). CalPERS has requirements that must be met in order to allow a retired annuitant to work for a CalPERS employer without reinstatement. Due to the state of emergency caused by the COVID-19 pandemic, the Governor has enacted a series of Executive Orders to help mitigate

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the impacts of COVID-19, including relaxing the restrictions governing the hiring of retired annuitants. On December 14, 2020, the Governor signed into effect Executive Order N-84-20 to allow, among other things, for the suspension of the 960-work hour limitation provided under Government Code section 21221, subdivision (h) and for retirees to be appointed more than once to the same vacancy if the state or local public agency determines the retiree is to be engaged in mitigating the effects of the COVID-19 pandemic.

On May 6, 2021, the CalOptima Board of Directors adopted resolutions authorizing the hiring of two CalPERS Retired Annuitants, Dr. Donald Sharps and Dr. Richard Helmer to be appointed to two separate positions as Medical Director – Retired Annuitant in accordance with applicable laws. On December 22, 2021, due to the unforeseen vacancy in the position of Chief Medical Officer and the regulatory and contractual requirement to report changes in the status of this position within ten (10) calendar days of a vacancy, Dr. Helmer was appointed as the Interim Chief Medical Officer to fill this critical position and mitigate the effects of the COVID-19 pandemic. Upon the appointment of a permanent Chief Medical Officer on February 7, 2022, Dr. Helmer will be reappointed to the prior retired annuitant position he held as Medical Director – Retired Annuitant as permitted under Executive Order N-84-20.

In addition, due to the ongoing pandemic and needs of the organization, both Dr. Sharps and Dr. Helmer are expected to exceed the work hour limitations under Government Code section 21221(h). As permitted under Executive Order N-84-20, the work hour limitations are suspended if the local public agency determines the retirees are engaged in mitigating the effects of the COVID-19 pandemic. Both Dr. Helmer and Dr. Sharps play a critical role in mitigating the effects of the COVID-19 pandemic, with Dr. Helmer focused on the PACE members and Dr. Sharps focused on behavioral health services of CalOptima members. In addition, Dr. Helmer's temporary role in the position of Interim Chief Medical Officer is crucial in providing oversight and direction in medical operations at CalOptima, impacting hundreds of thousands of CalOptima members during this public health emergency.

The attached Resolutions memorialize the Board of Directors' findings and meet all requirements set forth by CalPERS and the Executive Order. The attached offer letters regarding the appointments of Dr. Sharps and Dr. Helmer to the interim retired annuitant positions, along with the adoption of the two resolutions and recommended Board actions, meet all the requirements for interim appointments and Executive Order N-84-20.

Fiscal Impact

There is no additional fiscal impact.

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Rationale for Recommendation

The recommended actions to appoint Dr. Sharps and Dr. Helmer will enable critical oversight of the BHI and PACE departments, along with direction of all medical affairs operations at CalOptima, by two uniquely qualified doctors and will ensure minimal interruption in business operations during the public health emergency while recruitments to fill the permanent positions are underway.

Attachments

1. Resolution No. 22-0203-02, Authorizing the continued appointment of a CalPERS retired annuitant in accordance with Government Code section 21221(h) and Executive Order N-84-20 during a public health emergency to mitigate the effects of the COVID-19 pandemic, and certifying the nature of the employment of Dr. Donald Sharps
2. Offer Letter for Dr. Donald Sharps
3. Resolution No. 22-0203-03 authorizing the hiring of a CalPERS retired annuitant in accordance with Government Code section 21222(h) and Executive Order N-84-20 to the position of Interim Chief Medical Officer during a public health emergency to mitigate the effects of the COVID-19 pandemic, reappointing a retired annuitant to the position of Medical Director – Retired Annuitant thereafter during a public health emergency to mitigate the effects of the COVID-19 pandemic, and certifying the nature of the employment of Dr. Richard Helmer
4. Offer Letter for Dr. Richard Helmer
5. Executive Order N-84-20
6. Chief Medical Officer Job Description
7. Medical Director Job Description
8. CalOptima Salary Schedule

Concurrence

Gary Crockett, Chief Counsel

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0203-02

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY

AUTHORIZING THE CONTINUED APPOINTMENT OF A CALPERS RETIRED ANNUITANT IN ACCORDANCE WITH GOVERNMENT CODE SECTION 21221(h) AND EXECUTIVE ORDER N-84-20 DURING A PUBLIC HEALTH EMERGENCY TO MITIGATE THE EFFECTS OF THE COVID-19 PANDEMIC, AND CERTIFYING THE NATURE OF THE EMPLOYMENT OF DR. DONALD SHARPS

WHEREAS, Government (Gov.) Code section 21221(h) of the Public Employees' Retirement Law permits the governing body to appoint a CalPERS retiree to a vacant position requiring specialized skills during recruitment for a permanent appointment, and provides that such appointment will not subject the retired person to reinstatement from retirement or loss of benefits so long as it is a single appointment that does not exceed 960 hours in a fiscal year; and

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

WHEREAS, on December 14, 2020, the Governor signed into effect Executive Order N-84-20 to allow, among other things, for the suspension of the 960-hour limitation under Government Code section 21221(h) and for retirees to be appointed more than once to the same vacancy if the state or local public agency determines the retiree is to be engaged in mitigating the effects of the COVID-19 pandemic; and

WHEREAS, on November 10, 2021, the Governor extended the state of emergency through March 31, 2022; and

WHEREAS, Dr. Donald Sharps retired from CalOptima in the position of Medical Director, Behavioral Health Integration, effective March 26, 2021; and

WHEREAS, on May 6, 2021, the CalOptima Board of Directors adopted Resolution No. 21-0506-02, Approving an Exception to the 180-Day Waiting Period, Authorizing the Hiring of a CalPERS Retired Annuitant in Accordance with Government Code Section 7522.56 & 21221(h), and Certifying the Nature of the Employment of Dr. Donald Sharps; and

WHEREAS, the CalOptima Board of Directors, CalOptima, and Dr. Donald Sharps certify that Dr. Donald Sharps has not and will not receive a Golden Handshake or any other retirement-related incentive; and

WHEREAS, an appointment under Gov. Code section 21221(h) requires that the retiree is appointed into the interim appointment during recruitment for a permanent appointment; and

WHEREAS, the governing body has authorized the search for a permanent appointment on May 6, 2021, but no permanent appointment has been made to date; and

WHEREAS, as a result of the COVID-19 pandemic and the vacancy in the position of Medical Director, Behavioral Health Integration, the appointment of Dr. Donald Sharps as an interim appointment retired annuitant to the vacant position of Medical Director, Behavioral Health Integration for CalOptima is projected to exceed the work hour limitations under Gov. Code section 21221(h); and

WHEREAS, in the role of Medical Director, Behavioral Health Integration, Dr. Donald Sharps is and will continue to be engaged in mitigating the effects of the COVID-19 pandemic, particularly for CalOptima members; and

WHEREAS, the entire employment appointment document between Dr. Donald Sharps and CalOptima has been reviewed by this body and is attached herein; and

WHEREAS, the compensation paid to retirees cannot be less than the minimum nor exceed the maximum monthly base salary paid to other employees performing comparable duties, divided by 173.333 to equal the hourly rate; and

WHEREAS, the maximum monthly base salary for this position is $33,166, and the hourly equivalent is $191.35, and the minimum monthly base salary for this position is $22,167, and the hourly equivalent is $127.88; and

WHEREAS, the hourly rate paid to Dr. Donald Sharps will be $191.35; and

WHEREAS, Dr. Donald Sharps has not and will not receive any other benefit, incentive, compensation in lieu of benefit or other form of compensation in addition to this hourly pay rate.

NOW, THEREFORE, BE IT RESOLVED:

I. That the CalOptima Board of Directors hereby certifies the nature of the employment of Dr. Donald Sharps as described herein and detailed in the attached employment appointment document. The CalOptima Board of Directors finds that this appointment is necessary to fill the critically needed position of Medical Director, Behavioral Health Integration (BHI Medical Director) for CalOptima, because the work performed by the BHI Medical Director is critical to the successful operation of this Medi-Cal required behavioral health benefit and must continue while CalOptima recruits to fill the vacancy, in order to: provide oversight; monitor regulatory compliance; direct utilization reviews, quality and case management, health

education, and grievance & appeals activities; assist with the development and eventual implementation of the California Advancing & Innovating Medi-Cal (CalAIM) program; and collaborate with the County of Orange and the Organized Delivery System Drug Medi-Cal (ODS-DMC). No other CalOptima Medical Directors, current or previously employed, possess the knowledge and experience to oversee BHI immediately. Having been in the role of the BHI Medical Director position since the inception of the BHI program, Dr. Sharps is the most qualified individual to fill the gap during the recruitment process.

II. The Board finds that the continued engagement of Dr. Donald Sharps is necessary to mitigate the effects of the COVID-19 pandemic and ensure continuity in services provided to CalOptima members. Accordingly, as permitted under Executive Order No. 84-20, the work hour limitations under Government Code section 21221, subdivision (h), is suspended, allowing Dr. Sharps to work beyond the 960-hour limit for the fiscal year. This appointment shall continue through the state of emergency and will remain in effect until terminated by CalOptima or Dr. Sharps, or until Executive Order N-84-20 is withdrawn or revoked by the Governor or subsequent law, whichever is earlier.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this February 3, 2022.

AYES: _____
NOES: _____
ABSENT: _____
ABSTAIN: _____

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

Attest:

/s/_____
Sharon Dwiers, Clerk of the Board

February 4, 2022

Donald Sharps, M.D.
[redacted]

Dear Donald,

It is my pleasure to update you on your temporary employment as an As-Needed, Medical Director – Retired Annuitant. Consistent with Executive Order N-84-20, the CalOptima Board of Directors has determined that your continued appointment is necessary to mitigate the effects of the COVID-19 pandemic. Therefore, you are permitted to exceed the work hour limitation of 960 hours per fiscal year until terminated by you or CalOptima, the withdrawal or revocation of Executive Order N-84-20, or a permanent employee is hired into the position, whichever comes first. If you are a member of any other public retirement system, it is your responsibility to ensure the total time worked is consistent with the requirements and limitations of the other public retirement system.

You will receive an hourly rate of $191.35 payable according to CalOptima's usual payroll schedule, with appropriate deductions withheld as required under federal, state, and local tax laws. You will also receive reimbursement for pre-approved/reasonable costs and expenses incurred while performing your obligations as a Medical Director in accordance with reimbursement policies established by the CalOptima Board of Directors. As a retired annuitant, you are not eligible to receive employee benefits or holiday pay, and you will not accrue paid time off applicable to permanent employees. As a retiree, you must be enrolled as a retired annuitant and payrate with hours worked reported in the "my|CalPERS" system. No retirement contributions are reported by the employer or member for retired annuitants.

All employment at CalOptima is at-will, which means that either the employee or CalOptima may end the employment relationship at any time, with or without cause. By signing this offer letter, you agree and understand that your employment relationship with CalOptima is at-will with no guarantee of employment for any specified term. By signing this offer letter, you agree that this is the final and full agreement regarding the at-will nature of your employment relationship and cannot be later altered unless the Chief Executive Officer of CalOptima and you sign an agreement to the contrary.

Please be advised that you will be a Designated Employee pursuant to CalOptima's Conflict of Interest Code and therefore subject to its provisions, including the annual filing of California Fair Political Practices Commission Form 700: Statement of Economic Interests. Furthermore, because of the sensitive nature of your job responsibilities with CalOptima, your subsequent employment with an entity contracted to provide services to CalOptima creates a potential conflict of interest. You must therefore agree to notify promptly and in writing the CalOptima CEO and the Chair of

the Board of Directors if, up to twelve (12) months after terminating employment with CalOptima, you obtain employment with a CalOptima contractor. You must also agree that, during the twelve months after terminating employment with CalOptima, you will not be directly or indirectly involved in negotiating, servicing, or soliciting contracts with CalOptima for a contractor by whom you have been employed, or otherwise retained. For one (1) year following separation, you must agree not to actively recruit, solicit, or offer employment to any current CalOptima employee.

I know that with your extensive knowledge and experience, you will bring critical expertise and important perspective that will be of great value to us in this vital position to provide continuity in service during this statewide emergency. I believe that you will find this role rewarding as you assist CalOptima in its important mission to deliver quality, accessible, and efficient health care services to its members. We look forward to a positive and productive working relationship. As verification that you accept this offer, please sign the enclosed copy of this letter and return it to me by February 5, 2022.

Sincerely,

Michael Hunn
Interim Chief Executive Officer

UNEMPLOYMENT CERTIFICATION

By signing below, I hereby certify that I have not received any unemployment insurance payments within the twelve (12) months prior to this appointment and I have not provided previous retired annuitant work with any other CalPERS employer.

Date: _____ Accepted: _____
Donald Sharps

Name (Print): _____

ACKNOWLEDGMENT AND ACCEPTANCE

By signing below, I hereby accept the offer as described in this letter dated February 4, 2022 and understand that it is a conditional offer, which can be revoked. I understand that the position is an As-Needed retired annuitant position with no expectation of continuous employment. I understand that this is a temporary employment to mitigate the effects of the COVID-19 pandemic and that I am permitted to exceed the 960 hours per fiscal year work hour limitation for this limited purpose.

I understand that if I am a member of another public retirement system, it is my responsibility to ensure that my work hours are consistent with the requirements or limitations of the other public retirement system.

Date: _____ Accepted: _____
Donald Sharps

Name (Print): _____

RESOLUTION NO. 22-0203-03

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY

d.b.a. CalOptima

AUTHORIZING THE HIRING OF A CALPERS RETIRED ANNUITANT IN ACCORDANCE WITH GOVERNMENT CODE SECTION 21221(h) AND EXECUTIVE ORDER N-84-20 TO THE POSITION OF INTERIM CHIEF MEDICAL OFFICER DURING A PUBLIC HEALTH EMERGENCY TO MITIGATE THE EFFECTS OF THE COVID-19 PANDEMIC, REAPPOINTING A RETIRED ANNUITANT TO THE POSITION OF MEDICAL DIRECTOR – RETIRED ANNUITANT THEREAFTER DURING A PUBLIC HEALTH EMERGENCY TO MITIGATE THE EFFECTS OF THE COVID-19 PANDEMIC, AND CERTIFYING THE NATURE OF THE EMPLOYMENT OF DR. RICHARD HELMER

WHEREAS, Government (Gov.) Code section 21221(h) of the Public Employees' Retirement Law permits the governing body to appoint a CalPERS retiree to a vacant position requiring specialized skills during recruitment for a permanent appointment, and provides that such appointment will not subject the retired person to reinstatement from retirement or loss of benefits so long as it is a single appointment that does not exceed 960 hours in a fiscal year; and

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

WHEREAS, on December 14, 2020, the Governor signed into effect Executive Order N-84-20 to allow, among other things, for the suspension of the 960-hour limitation under Government Code section 21221(h) and for retirees to be appointed more than once to the same vacancy if the state or local public agency determines the retiree is to be engaged in mitigating the effects of the COVID-19 pandemic; and

WHEREAS, on May 6, 2021, the CalOptima Board of Directors adopted Resolution No. 21-0506-03, Authorizing the Hiring of a CalPERS Retired Annuitant in Accordance with Government Code Section 21221(h), and Certifying the Nature of the Employment of Dr. Richard Helmer; and

WHEREAS, on November 10, 2021, the Governor extended the state of emergency through March 31, 2022; and

WHEREAS, due to an unforeseen vacancy in a critical position, the CalOptima Board of Directors desires to appoint Dr. Richard Helmer as an interim appointment retired annuitant to

the vacant position of Interim Chief Medical Officer for the period of December 22, 2021 through February 6, 2022, for CalOptima under Gov. Code section 21221(h) and to assume the roles and responsibilities of the Chief Medical Officer during the vacancy to mitigate the effects of the COVID-19 pandemic as permitted under Executive Order N-84-20; and

WHEREAS, effective February 7, 2022, the CalOptima Board of Directors desires to reappoint Dr. Richard Helmer as an interim appointment retired annuitant to the vacant position of Medical Director, PACE, Quality & Population Health for CalOptima under Gov. Code section 21221(h) and under Executive Order N-84-20 to mitigate the effects of the COVID-19 pandemic due to the vacancy in the position at the PACE center; and

WHEREAS, the CalOptima Board of Directors, CalOptima and Dr. Richard Helmer certify that Richard Helmer has not and will not receive a Golden Handshake or any other retirement-related incentive; and

WHEREAS, an appointment under Gov. Code section 21221(h) requires the retiree is appointed into the interim appointment during recruitment for a permanent appointment; and

WHEREAS, the governing body has authorized the search for a permanent appointment for Medical Director, PACE, Quality & Population Health on May 6, 2021, but no permanent appointment has been made to date; and

WHEREAS, Dr. Richard Helmer was temporarily appointed to the position of Interim Chief Medical Officer during the vacancy in this critical position, but a permanent appointment was made effective February 7, 2022; and

WHEREAS, as a result of the COVID-19 pandemic and the vacancies in both positions, the appointment is projected to exceed the work hour limitations under Gov. Code section 21221(h); and

WHEREAS, in both roles as Interim Chief Medical Officer and as Medical Director, PACE, Quality & Population Health, Dr. Richard Helmer is and will continue to be engaged in mitigating the effects of the COVID-19 pandemic, particularly for CalOptima members; and

WHEREAS, the entire employment appointment document between Dr. Helmer and CalOptima has been reviewed by this body and is attached herein; and

WHEREAS, the compensation paid to retirees cannot be less than the minimum nor exceed the maximum monthly base salary paid to other employees performing comparable duties, divided by 173.333 to equal the hourly rate; and

WHEREAS, the maximum monthly base salary for the Chief Medical Officer position is $46,000 and the hourly equivalent is $265.38, and the monthly minimum base salary for this position is $30,667, and the hourly equivalent is $176.92; and

WHEREAS, the hourly rate paid to Dr. Helmer for the Chief Medical Officer position will be $203.00; and

WHEREAS, the maximum monthly base salary for the Medical Director position is $33,166 and the hourly equivalent is $191.35, and the monthly minimum base salary for this position is $22,167, and the hourly equivalent is $127.88; and

WHEREAS, the hourly rate paid to Dr. Helmer for the Medical Director position will be $191.35; and

WHEREAS, Dr. Helmer has not and will not receive any other benefit, incentive, compensation in lieu of benefit or other form of compensation in addition to this hourly pay rate.

NOW, THEREFORE, BE IT RESOLVED THAT:

I. The CalOptima Board of Director hereby certifies the nature of the employment of Dr. Richard Helmer as described herein and detailed in the attached employment appointment document and that this appointment is necessary to fill the critically needed position of Interim Chief Medical Officer and Medical Director, PACE, Quality and Population Health (PACE Medical Director) for CalOptima because the work performed by the Chief Medical Officer and PACE Medical Director is critical to the successful operation of CalOptima and PACE and must continue while CalOptima recruits to fill the vacancy. The Chief Medical Officer provides oversight and direction in the medical operations of CalOptima, impacting hundreds of thousands of CalOptima members. The PACE Medical Director provides clinical leadership to the PACE program and participates in the development and implementation of the PACE program, including policies and procedures for clinical services and the quality assurance program initiatives (QAPI), oversees the clinical care provided by the CalOptima PACE program and ensures quality clinical service delivery to PACE participants,

and provides oversight of the physicians, nurse practitioners, pharmacists, and other staff. Having previously served in the role of Chief Medical Officer in the past, Dr. Helmer has insight and knowledge regarding CalOptima's operations, and Dr. Helmer is qualified to fill the gap during the recruitment process.

II. The Board finds that the engagement of Dr. Helmer is necessary to mitigate the effects of the COVID-19 pandemic and ensure continuity in services provided to CalOptima members. Accordingly, as permitted under Executive Order No. 84-20, the reinstatement and work hour limitations under Government Code section 21221, subdivision (h), is suspended, allowing Dr. Helmer to work beyond the 960-hour limit for the fiscal year and allowing Dr. Helmer to be appointed to the position of Chief Medical Officer and reappointed to the position of Medical Director, PACE, Quality & Population Health thereafter. This appointment shall continue through the state of emergency and will remain in effect until terminated by CalOptima or Dr. Helmer, or until Executive Order N-84-20 is withdrawn or revoked by the Governor or subsequent law, whichever is earlier.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this February 3, 2022.

AYES: _____
NOES: _____
ABSENT: _____
ABSTAIN: _____

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

Attest:

/s/_____
Sharon Dwiers, Clerk of the Board

February 4, 2022

Richard Helmer M.D.
[redacted]

Dear Richard,

It is my pleasure to confirm to you an offer of temporary employment as an As-Needed, Interim Chief Medical Officer – Retired Annuitant, for the period of December 22, 2021, to February 6, 2022. Thereafter, you will be reappointed to the prior position as Medical Director – Retired Annuitant to mitigate the effects of the COVID-19 pandemic. Consistent with Executive Order N-84-20, the CalOptima Board of Directors has determined that your continued appointment is necessary to mitigate the effects of the COVID-19 pandemic. Therefore, you are permitted to exceed the work hour limitation of 960 hours per fiscal year until terminated by you or CalOptima, the withdrawal or revocation of Executive Order N-84-20, or a permanent employee is hired into the applicable position, whichever comes first. In addition, your reappointment to the position of Medical Director – Retired Annuitant following your temporary appointment as Interim Chief Medical Officer – Retired Annuitant is also permitted under Executive Order N-84-20. If you are a member of any other public retirement system, it is your responsibility to ensure the total time worked is consistent with the requirements and limitations of the other public retirement system.

In the position of Interim Chief Medical Officer – Retired Annuitant, you will receive an hourly rate of $203.00 payable according to CalOptima's usual payroll schedule, with appropriate deductions withheld as required under federal, state, and local tax laws. Upon reappointment to the position of Medical Director – Retired Annuitant, you will receive an hourly rate of $191.35 payable according to CalOptima's usual payroll schedule, with appropriate deductions withheld as required under federal, state, and local tax laws. You will also receive reimbursement for pre-approved/reasonable costs and expenses incurred while performing your obligations as a Medical Director in accordance with reimbursement policies established by the CalOptima Board of Directors. As a retired annuitant, you are not eligible to receive employee benefits or holiday pay, and you will not accrue paid time off applicable to permanent employees. As a retiree, you must be enrolled as a retired annuitant and your payrate with hours worked reported in the "my|CalPERS" system. No retirement contributions are reported by the employer or member for retired annuitants.

All employment at CalOptima is at-will, which means that either the employee or CalOptima may end the employment relationship at any time, with or without cause. By signing this offer letter, you agree and understand that your employment relationship with CalOptima is at-will with no guarantee of employment for any specified term. By signing this offer letter, you agree that this is the final and full agreement regarding the at-will nature of your employment relationship and

cannot be later altered unless the Chief Executive Officer of CalOptima and you sign an agreement to the contrary.

Please be advised that you will be a Designated Employee pursuant to CalOptima's Conflict of Interest Code and therefore subject to its provisions, including the annual filing of California Fair Political Practices Commission Form 700: Statement of Economic Interests. Furthermore, because of the sensitive nature of your job responsibilities with CalOptima, your subsequent employment with an entity contracted to provide services to CalOptima creates a potential conflict of interest. You must therefore agree to notify promptly and in writing the CalOptima CEO and the Chair of the Board of Directors if, up to twelve (12) months after terminating employment with CalOptima, you obtain employment with a CalOptima contractor. You must also agree that, during the twelve (12) months after terminating employment with CalOptima, you will not be directly or indirectly involved in negotiating, servicing, or soliciting contracts with CalOptima for a contractor by whom you have been employed, or otherwise retained. For one (1) year following separation, you must agree not to actively recruit, solicit, or offer employment to any current CalOptima employee.

I know that with your extensive knowledge and experience you will bring critical expertise and important perspective that will be of great value to us in this vital position to provide continuity in service during this statewide emergency. I believe that you will find this role rewarding as you assist CalOptima in its important mission to deliver quality, accessible, and efficient health care services to its members. We look forward to a positive and productive working relationship. As verification that you accept this offer, please sign the enclosed copy of this letter and return it to me by February 5, 2022.

Sincerely,

Michael Hunn
Interim Chief Executive Officer

UNEMPLOYMENT CERTIFICATION

By signing below, I hereby certify that I have not received any unemployment insurance payments within the twelve (12) months prior to this appointment, and I have not provided previous retired annuitant work with any other CalPERS employer

Date: _____ Accepted: _____
Richard Helmer

Name (Print): _____

ACKNOWLEDGMENT AND ACCEPTANCE

By signing below, I hereby accept the offer as described in this letter dated February 4, 2022 and understand that it is a conditional offer, which can be revoked. I understand that the position is an As-Needed retired annuitant position with no expectation of continuous employment. I understand that this is a temporary employment to mitigate the effects of the COVID-19 pandemic and that I am permitted to exceed the 960 hours per fiscal year work hour limitation and be reappointed to the position of Medical Director – Retired Annuitant consistent with Executive Order N-84-20 for this limited purpose. I understand that if I am a member of another public retirement system, it is my responsibility to ensure that my work hours are consistent with the requirements or limitations of the other public retirement system.

Date: _____ Accepted: _____
Richard Helmer

Name (Print): _____

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-84-20

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS the COVID-19 pandemic necessitates physical distancing measures and households to stay at home in order to minimize further spread of the disease; and

WHEREAS the COVID-19 pandemic has exacerbated the already critical housing crisis faced by Californians such that finding new housing during this time both poses health risk and is extremely burdensome, especially for migratory agricultural workers and their families; and

WHEREAS previous suspensions of certain limitations applicable to retired annuitants have bolstered state and local efforts to mitigate the effects of the COVID-19 pandemic, and additional flexibility in this space will further enhance state and local agencies' response to the pandemic; and

WHEREAS the COVID-19 pandemic, as well as physical distancing and other public health measures undertaken in response to it, continue to affect individuals, businesses, and governmental agencies alike, with associated impacts on adherence to certain statutory and regulatory deadlines and requirements; and

WHEREAS on November 30, 2020, the emergency temporary standard concerning COVID-19 prevention in places of employment (ETS) and codified in California Code of Regulations, Title 8, section 3205-3205.4 took effect; and

WHEREAS the ETS directed employers to exclude from the workplace for 14 days those employees who have been exposed to COVID-19, reflecting the then-current guidance of the Centers for Disease Control and Prevention (CDC) and the California Department of Public Health (CDPH) on quarantining after being exposed to COVID-19; and

WHEREAS on December 14, 2020, CDPH published Updated COVID-19 Quarantine Guidance that sets forth new directives, based upon CDC guidelines, for when employees exposed to COVID-19 who are asymptomatic may discontinue quarantine; and

WHEREAS public health recommendations and the requirements of the ETS should be consistent in order to protect public health; and

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

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NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and statutes of the State of California, and in particular, Government Code sections 8567, 8571, and 8627, do hereby issue the following Order to become effective immediately:

IT IS HEREBY ORDERED THAT:

1) Health and Safety Code section 50710.1, subdivision (c), paragraph (8), and any related implementing regulations, are suspended to the limited extent that they:

    a. Prevent a migrant farm labor center assisted by the Department of Housing and Community Development from operating for more than 275 days in a calendar year in order to protect the health and safety of existing tenants during the COVID-19 pandemic; or

    b. Prevent existing tenants of such a center who need to continue occupying the center for health and safety reasons related to the COVID-19 pandemic from occupying the center for more than 275 days in a calendar year.

2) If health and safety reasons related to the COVID-19 pandemic warrant extending an occupancy period as permitted under paragraph 1 of this Order, the following requirements shall also be suspended:

    a. The petition and notice requirements in Health and Safety Code section 50710.1, subdivision (c), paragraph (3).

    b. The requirement in Health and Safety Code section 50710.1, subdivision (c), paragraph (4) to request an extended occupancy period, and for the Department to notify the entity operating the migrant farm labor center and residents of its final decision no later than seven days prior to the center's scheduled opening or closing date.

    c. The notice requirement in Health and Safety Code section 50710.1, subdivision (c), paragraph (7).

3) The eligibility requirement of Health and Safety Code section 50710.3, subdivision (a), and any related implementing regulations, for a migratory agricultural worker to have resided outside a 50-mile radius of the migrant farm labor center for at least three months out of the preceding six-month period shall be suspended for workers who do not satisfy the eligibility requirements because they needed to continue occupying a migrant farm labor center for health and safety reasons related to the COVID-19 pandemic.

4) The reinstatement and work hour limitations in Government Code section 21221, subdivision (h) (including, in particular, the limitation that a retiree may only be appointed to a vacant position once) are suspended as applied to retired persons whom the relevant state or

local public agency determines to be engaged in (or whom the relevant state or local public agency seeks to engage in) mitigating the effects of the COVID-19 pandemic.

5) In order to quickly provide relief from interest and penalties for businesses impacted by the proclaimed emergency of COVID-19, the provisions of the Revenue and Taxation Code that apply to the taxes and fees administered by the Department of Tax and Fee Administration requiring a request for an extension or the filing of a statement under penalty of perjury may be suspended by the Department for a period of up to three months after the due date of the return or payment for individuals or businesses filing a return for less than $1,000,000 in taxes or fees. This is effective after the date of this Order and shall remain effective through the reporting of taxes or fees due or the payment of taxes or fees that are due on or by April 30, 2021.

6) The deadline specified in Government Code section 1774(c) (related to the Senate's confirmation of an individual appointed or reappointed by the Governor to an office) is extended until April 1, 2021 for an individual appointed or reappointed to an office specified in Welfare and Institutions Code section 1718, subdivision (a).

7) The exclusion periods required in California Code of Regulations, Title 8, section 3205(c)(10) and the periods for which a worker shall not return to work specified in section 3205(c)(11) shall be suspended to the extent that they exceed the longer of:

    a. Any applicable quarantine or isolation period recommended by the CDPH, including in the December 14, 2020 Updated COVID-19 Quarantine Guidelines; or

    b. Any applicable quarantine or isolation period recommended or ordered by a local health officer who has jurisdiction over the workplace.

8) The suspension in paragraph 7 shall not apply where an employer prevents a worker who returns to work earlier than permitted under the ETS as enacted on November 30, 2020 from satisfying any of the conditions specified by the CDPH or a local health officer that are applicable to the periods specified in Paragraph 7, subparagraphs (a) or (b) above.

9) If the Department of Industrial Relations, Division of Occupational Safety and Health (Cal/OSHA)'s enforcement of the exclusion periods required in California Code of Regulations, Title 8, section 3205(c)(10) or the periods for which a worker shall not return to work specified in section 3205(c)(11) changes, Cal/OSHA shall promptly provide public notice of the change, including through posting notice on its web page regarding the ETS, https://www.dir.ca.gov/dosh/coronavirus/ETS.html.

IT IS FURTHER ORDERED that, as soon as hereafter possible, this Order be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this Order.

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 14th day of December 2020.



GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

Chief Medical Officer (CMO)

Department(s): Medical Management
Reports to: Chief Executive Officer (CEO), with direct access to the Board of Directors
FLSA status: Exempt
Revised: 12/22/2021

Job Summary

The Chief Medical Officer oversees the agency's medical care delivery system, including the development and implementation of strategies, programs, policies, and procedures for all medical services, clinical operations and quality programs. The incumbent establishes standards for evaluating providers for inclusion in CalOptima's program and for the ongoing performance of participating providers. The incumbent is responsible for determinations of medical necessity and appropriateness of medical services. The CMO works with Directors and Medical Directors in the operational oversight of the medical division, including, but not limited to, Quality Improvement, Quality Analytics, Utilization Management, Case Management, Population Health Management, Pharmacy Management, Long-Term Care, Behavioral Health Integration, Enterprise Analytics, and Program of the All-Inclusive Care for the Elderly (PACE). Additionally, the CMO shall ensure that the care provided by the delegated networks meet all quality and regulatory requirements.

Position Responsibilities:

- Ensures the CalOptima mission, to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.
- Oversees functional areas of CalOptima's medical management programs.
- Ensures compliance with regulatory timelines, including, but not limited to timeliness of Treatment Authorizations and Appeals.
- Prepares materials for and participates in public meetings such as the Board of Directors, Quality Assurance Committee, Provider Advisory Committee and Member Advisory Committee.
- Collaborates and coordinates with the delegated network providers (physicians, medical groups, and hospitals) to ensure the delivery of quality, compliant care to members.
- Represents CalOptima to key stakeholders and community-based organizations in support of member services, CalAIM, and County of Orange initiatives.
- Maintains and improves CalOptima's National Committee on Quality Assurance (NCQA) accreditation scores and Centers for Medicare & Medicaid Services (CMS) ratings.
- Collaborates with other departments to develop and implement effective programs.
- Ensures Medical Affairs is fully prepared for all regulatory (CMS, California Department of Health Care Services (DHCS), California Department of Managed Health Care (DMHC)) and NCQA routine and special audits.

- Recruits, develops, and retains a strong management and clinical team within Medical Affairs.
- Works effectively and collaboratively with the CalOptima senior leadership team, Orange County Healthcare Agency, and other key stakeholder groups.
- Represents CalOptima to state and federal regulators, accreditation organizations, and other local and national health care professional organizations, associations, and partnerships.
- Drives innovative solutions for program development and implementation to improve access, satisfaction, and care outcomes that are both sustainable and scalable.
- Manages special projects as requested by the Chief Executive Officer or the Board of Directors.
- Other projects and duties as assigned.

Possesses the Ability to:

- Conceptualize, develop, and implement health care delivery policy in an effective managed care system, including the delegated model.
- Plan, organize, and direct utilization review, quality management, case management, treatment authorization, and appeals activities.
- Proactively outreach to physicians, medical groups, group CMOs and clinical leaders, and other providers, as a practitioner and clinician, and provide effective influence and leadership.
- Establish and maintain effective interpersonal relationships with all levels of staff, other programs, agencies, and the general public.
- Direct and participate in the development of strategic and clinical initiatives work plans.
- Embrace and integrate clinical informatics and technological solutions to drive quality initiatives and clinical excellence in coordination with other departments including Analytics and Information Technology Services (ITS).
- Communicate clearly and concisely, both verbally and in writing, at all organizational levels and in situations requiring instructing, persuading, negotiating, consulting, and advising.
- Utilize computer and appropriate software (e.g., Microsoft Office: Excel, Outlook, PowerPoint, Word) and job-specific applications/systems to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment.

Experience & Education:

- Medical Doctor degree from a fully accredited university required.
- Board Certification, preferably in an area of Primary Care such as Pediatrics, Family Practice, or Internal Medicine required.
- Current unrestricted Physician & Surgeons' License to practice in the State of California required.
- 10 years of experience as a Physician leader with demonstrated record of leading and implementing Medical Management in a managed care organization required.

Preferred Qualifications:

- Medicare and Medicaid experience strongly preferred.
- Experience in NCQA accreditation and CMS star ratings within a health plan preferred.

Knowledge of:

- Medi-Cal and Medicare managed care including understanding of contracts and at-risk arrangements with providers.
- Industry and professional standards of health care, utilization management, quality improvement and other medical management functions.
- Principles and techniques of effective human resource management, including training and evaluation and effective utilization of staff.
- Financial reporting, budgeting, and operational management.
- Principles and practices of health care, health care systems, medical quality assurance, and medical management.
- Required governmental and other reporting criteria (i.e., NCQA, HEDIS).

Physical Demands & Work Environment

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- *Physical demands:* While performing duties of the job, employee may be required to move about the organization. Employee must be able to sit for extended periods of time, as well as work at the computer for long periods. Employee is required to use hands and fingers, especially for typing on the computer and using the mouse. Employee must be able to communicate, particularly for regular phone use, in meetings, conducting presentations, and face-to-face interaction. Must be able to tolerate a high level of stress and be able to operate under pressure. Occasional travel is required.

- *Work environment:* Office environment with minimal noise levels and controlled office temperatures. Fast-paced work environment; ability to juggle multiple priorities is often required.

Disclaimer:

The Job duties, elements, responsibilities, skills, functions, experience, educational factors and the requirements and conditions listed in this job description are representative only and not exhaustive of the tasks that an employee may be required to perform. The Employer reserves the right to revise this job description at any time and to require employees to perform other tasks as circumstances or conditions of its business, competitive considerations, or work environment change.

Medical Director (Behavioral Health)

Department(s): Medical Management
Reports to: Chief Medical Officer (CMO)
FLSA status: Exempt
Revised: 02/12/2021

Job Summary

The Medical Director for Behavioral Health (BH) is responsible for clinical oversight and management of CalOptima's behavioral health activities including, case management, utilization management, quality management, and contracted services.

Position Responsibilities

- Provides strategic direction for the Behavioral Health Department.
- Provides quality oversight and lead the quality efforts for Behavioral Health.
- Develops and implements medical policies for Behavioral Health.
- Provides direction and control of current medical practices for Behavioral Health ensuring that medical personnel for the plan follow medical protocols and rules of conduct.
- Ensures that medical decisions regarding behavioral health are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Oversees reporting and profiling of behavioral health providers.
- Ensures the appropriate and timely use of criteria and guidelines in the administration of behavioral health treatment.
- Ensures that assigned patients are provided behavioral health services and necessary medical attention at all locations.
- Works with the Contracting department to ensure a full and appropriate primary and specialty behavioral health care provider network for members.
- Consults on written protocol for behavioral health providers to ensure adherence to standards and quality of care. Coordinate professional interactions amongst practitioners and lend assistance toward correcting any deviation from standards. Develop relationships with directly contracted behavioral health providers.
- Participates in the quality management program for behavioral health providers which includes protocol, procedures, oversight, and training in the following areas:
  - Provider selection
  - Credentialing
  - Quality assessment studies
  - Peer review activities

  - Referral management
  - Pre-admission authorization
  - Prospective, concurrent and retrospective review
  - Utilization review reporting and evaluation
  - Case management
  - NCQA accreditation
- Reviews State and Federal mandated benefits to ensure CalOptima Behavioral Health is in full compliance through its providers.
- Ensures the privacy and security of Protected Health Information (PHI) as outlined in CalOptima's policies and procedures relating to HIPAA compliance.
- Any other duties as required to ensure the plan operations are successful.
- Other projects and duties as assigned.

Possesses the Ability To:

- Manage a large point of service network of providers.
- Develop and implement appropriate medical service contracts and monitor compliance.
- Plan, organize, and direct utilization review, quality management, case management, health education, and grievance activities.
- Ensure appropriate and cost-effective medical care and services to members not covered by a contracted health plan.
- Establish and maintain effective interpersonal relationships with all levels of staff, other programs, agencies, and the general public.
- Communicate clearly and concisely, both verbally and in writing.
- Utilize computer and appropriate software (e.g., Microsoft Office: Word, Outlook, Excel, PowerPoint) and job specific applications/systems to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment.

Experience & Education:

- Current, valid, unrestricted California Physician and Surgeon's License with Board certification in Psychiatry required.
- 5+ years of Medical Administrative experience required.
- Utilization Management experience with expertise in Medi-Cal managed care and Medicare required.

Preferred Qualifications:

- Sub-specialization or additional training and experience in substance use disorder with understanding of American Society of Addiction Medicine (ASAM) Levels-of-Care with the County Organized Delivery System Drug Medi-Cal (ODS – DMC) preferred.
- Additional training with children including understanding of County Levels-of-Care, Regional Center, and Applied Behavioral Analysis for Autism Spectrum Disorder (ASD), Intellectual Disabilities and other non-ASD diagnoses preferred.
- Expertise in medical program design preferred.

Knowledge of:

- Electronic Health Records (EHR) typically used by Behavioral Health (BH) provider, Medical Providers, Hospitals and Managed Care.
- Administrative practices and procedures including but not limited to quality assessment and improvement, utilization review, peer review, credentialing, and risk management.
- Rules regulations, policies, and standards related to managed care, including California Department of Health Care Services (DHCS), and California Department of Managed Care Services (DHMS)
- Effective supervision and organization.
- Pay for Value reimbursement and other innovative BH provider reimbursement that focuses on quality.
- Medi-Cal services coordination with Local Education Authorities (LEA)
- Methods, techniques, practices, principles, and literature in Psychiatry including psychopharmacology for formulary and non-formulary medications, other psychiatric treatments including innovative / experimental treatments.
- Methods, techniques, practices, principles, and literature in the broad field of medical sciences and an overview of the highly specialized techniques, procedures and equipment used in the medical or surgical specialists.

Physical Demands and Work Environment

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- *Physical demands:* While performing duties of job, employee may be required to move about the organization. Employee must be able to sit for extended periods of time, as well as work at the computer for long periods. Employee is required to use hands and fingers, especially for typing on the computer and using the mouse. Employee must be able to communicate, particularly for regular phone use and in meetings. Must have means of transportation, as occasional travel is required.

- *Work Environment:* Typical office environment with minimal to moderate noise levels and controlled office temperatures. Off-site work environment varies depending on location.

Disclaimer:

The Job duties, elements, responsibilities, skills, functions, experience, educational factors and the requirements and conditions listed in this job description are representative only and not exhaustive of the tasks that an employee may be required to perform. The Employer reserves the right to revise this job description at any time and to require employees to perform other tasks as circumstances or conditions of its business, competitive considerations, or work environment change.

CalOptima - Annual Base Salary Schedule - Revised September 2, 2021
To be Implemented September 12, 2021
Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$368,000	$460,000	$552,000
**	Chief Executive Officer	Z	138	$560,000	$625,000	$765,000
**	Chief Financial Officer	X	134	$368,000	$460,000	$552,000
**	Chief Information Officer	W	131	$313,000	$391,000	$469,000
**	Chief of Staff	U	TBD	$226,000	$282,000	$338,000
**	Chief Medical Officer	X	137	$368,000	$460,000	$552,000
**	Chief Operating Officer	Y	136	$433,000	$540,909	$649,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Claims Examiner	C	9	$41,000	$47,000	$53,000
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Communications Specialist Sr	H	TBD	$59,000	$68,000	$77,000
	Communications Specialist - Lead	J	TBD	$65,000	$78,000	$91,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000

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	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$313,000	$391,000	$469,000
**	Deputy Chief Medical Officer	W	561	$313,000	$391,000	$469,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S	392	$154,000	$193,000	$232,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Data Management Services	Q	TBD	$130,000	$157,000	$184,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R	675	$144,000	$174,000	$204,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Behavioral Health Integration	U	614	$226,000	$282,000	$338,000
**	Executive Director Clinical Operations	U	501	$226,000	$282,000	$338,000
**	Executive Director Compliance	U	493	$226,000	$282,000	$338,000

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**	Executive Director Finance	U	TBD	$226,000	$282,000	$338,000
**	Executive Director Human Resources	U	494	$226,000	$282,000	$338,000
**	Executive Director Network Operations	U	632	$226,000	$282,000	$338,000
**	Executive Director Operations	U	276	$226,000	$282,000	$338,000
**	Executive Director Program Implementation	U	490	$226,000	$282,000	$338,000
**	Executive Director Public Affairs	U	290	$226,000	$282,000	$338,000
**	Executive Director Quality & Population Health Management	U	676	$226,000	$282,000	$338,000
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000
	Financial Analyst	J	51	$65,000	$78,000	$91,000
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
	Graphic Designer	K	387	$70,000	$84,000	$98,000
	Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
	Health Coach	K	556	$70,000	$84,000	$98,000
	Health Educator	H	47	$59,000	$68,000	$77,000
	Health Educator Sr	I	355	$61,000	$73,000	$85,000
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
	Help Desk Technician	E	571	$48,000	$55,000	$62,000
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
	HR Assistant	D	181	$44,000	$51,000	$58,000
	HR Business Partner	M	584	$85,000	$103,000	$121,000
	HR Coordinator	F	316	$51,000	$59,000	$67,000
	HR Representative	J	278	$65,000	$78,000	$91,000
	HR Representative Sr	L	350	$77,000	$93,000	$109,000
	HR Specialist	G	505	$55,000	$63,000	$71,000
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
	Intern	A	237	$36,000	$41,000	$46,000
	Investigator Sr	I	553	$61,000	$73,000	$85,000
	IS Coordinator	E	365	$48,000	$55,000	$62,000
	IS Project Manager	N	424	$95,000	$114,000	$133,000
	IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
	IS Project Specialist	K	549	$70,000	$84,000	$98,000
	IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000

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Kitchen Assistant	A	585	$36,000	$41,000	$46,000
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000

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	Manager Provider Relations	M	171	$85,000	$103,000	$121,000
	Manager Purchasing	O	275	$105,000	$127,000	$149,000
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$266,000	$332,000	$398,000
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
	Physical Therapist	L	530	$77,000	$93,000	$109,000
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
	Privacy Manager	N	536	$95,000	$114,000	$133,000

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Privacy Officer	O	648	$105,000	$127,000	$149,000
Process Excellence Manager	N	529	$95,000	$114,000	$133,000
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
Receptionist	B	140	$38,000	$44,000	$50,000
Records Manager	Q	TBD	$130,000	$157,000	$184,000
Recreational Therapist	H	487	$59,000	$68,000	$77,000
Registered Dietitian	I	57	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
RN (PACE)	M	480	$85,000	$103,000	$121,000
Security Analyst Int	M	534	$85,000	$103,000	$121,000
Security Analyst Sr	N	474	$95,000	$114,000	$133,000
Security Officer	B	311	$38,000	$44,000	$50,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
	Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
	Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
	Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
	Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
	Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
	Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000

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Technical Analyst Int	J	64	$65,000	$78,000	$91,000
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 09/02/2021

Board of Directors Meeting
February 3, 2021

Special Joint Meeting of the Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee Report to the Board

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On December 9, 2021, the Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) and the Whole-Child Model Family Advisory Committee (WCM FAC) held a special joint meeting to discuss topics of mutual interest.

Michael Hunn, Interim Chief Executive Officer, updated the members on the status of several items of interest to the committees. He notified the committees that he would be meeting with California Health and Human Services Agency Secretary Dr. Mark Ghaly on December 13, 2021, along with other plan CEOs to discuss the many concerns related to the Medi-Cal Rx rollout. He assured the committees that CalOptima would be in high performance mode to ensure proper communication, proper outreach and mitigation of the many issues that may arise because of this new program. Mr. Hunn notified the committees that Veronica Carpenter had been appointed as the new Chief of Staff and would join CalOptima on December 13, 2021.

Yunkyung Kim, Chief Operating Officer, thanked all the advisory committees for their dedication, advice and guidance to CalOptima throughout this year. She notified the committees that Kelly Giardina had joined CalOptima as the Executive Director, Program Implementation, and noted that Ms. Giardina was assisting Dr. Fonda in an interim capacity overseeing the clinical operations team. Ms. Kim also notified the committee that Wael Younan had joined CalOptima as the Chief Information Officer. She also noted that CalOptima had partnered with the Orange County Health Care Agency to conduct a series of vaccine clinics. The clinics have been held in Anaheim and Irvine to date.

At the request of the MAC, PAC and WCM FAC, Emily Fonda, M.D., Chief Medical Officer, Kristen Gericke, PharmD., Director, Clinical Pharmacy, and Michael Weiss, M.D., Vice President, Population Health at Children's Hospital of Orange County (CHOC), were asked to provide an overview of Medi-Cal Rx to the committees and its anticipated impact to CalOptima members. Dr. Weiss presented on CHOC's efforts to add more medication to the current formulary to assist the most vulnerable children affected by the transition and help ensure that their access to needed medications will not be disrupted.

The committees also received a Chief Medical Officer Report from Dr. Fonda, a Public Affairs report from Rachel Selleck, Executive Director, Public Affairs, and a strategic plan update from Claudia Magee, Interim Director, Strategic Planning.

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

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