NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' FINANCE AND AUDIT COMMITTEE

THURSDAY, NOVEMBER 19, 2020
2:00 P.M.

505 CITY PARKWAY WEST, SUITE, 108-N
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS' FINANCE AND AUDIT COMMITTEE
Isabel Becerra, Chair
Clayton Corwin
Scott Schoeffel

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	Sharon Dwiers

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) 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' Finance and Audit Committee, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Committee, it is requested that you state your name for the record. Address the Committee as a whole through the Chair. Comments to individual Committee 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 of Directors' Finance and Audit Committee 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 +1 (914) 614-3221 Access Code: 496-143-003 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/944492993776941584 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PUBLIC COMMENTS
At this time, members of the public may address the Committee on matters not appearing on the agenda, but under the jurisdiction of the Board of Directors' Finance and Audit Committee. Speakers will be limited to three (3) minutes.

MANAGEMENT REPORTS
1. Chief Financial Officer Report

INVESTMENT ADVISORY COMMITTEE UPDATE
2. Treasurer's Report

CONSENT CALENDAR
3. Minutes
   a. Approve Minutes of the September 17, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee
   b. Receive and File Minutes of the July 20, 2020 Regular Meeting of the CalOptima Board of Directors' Investment Advisory Committee

REPORTS
4. Consider Recommending Board of Directors' Approval of Proposed Changes to CalOptima Policy GA.3400: Annual Investments

5. Consider Recommending that the Board of Directors' Authorize an Amendment to the Amended and Restated Development Agreement with the City of Orange to Extend CalOptima's Development Rights

6. Consider Recommending Board of Directors' Approval of Proposed Revisions to CalOptima's Operations Policies and Procedures

7. Consider Recommending Board of Directors' Authorization for the Reallocation of Budgeted but Unspent Salary Dollars to Expand the Scope of Work of a Contract for External Peer Review Services Contract and Extend a Contract for Medical Consulting Services

8. Consider Recommending Board of Directors' Approval of Actions Authorizing Extensions and Other Modifications of Whole Person Care Agreements with the Orange County Health Care Agency

9. Consider Recommending Board of Directors' Authorization of Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2020–2021 Capital Budget

INFORMATION ITEMS

10. Investment Advisory Committee Overview

11. Overview of the Office of Compliance

12. DHCS Medical Audit Corrective Action Plan Status

13. September 2020 Financial Summary

14. CalOptima Information Security Update

15. Quarterly Operating and Capital Budget Update

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

COMMITTEE MEMBER COMMENTS

CLOSED SESSION

CS-1. Pursuant to Government Code Section 54956.8: CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Property: 13300 Garden Grove Blvd, Garden Grove, CA 92843
Agency Negotiators: Justin Hodgdon, David Kluth, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Young S. Kim and Soon Y. Kim
Under Negotiation: Price and Terms of Payment

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee on November 19, 2020 2:00 PM PDT at: https://attendee.gotowebinar.com/register/944492993776941584
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 (914) 614-3221

   Access Code: 496-143-003

   Audio PIN: Shown after joining the webinar

Board of Directors' Finance and Audit Committee
November 19, 2020

Quarterly Treasurer's Report
July 1, 2020, through September 30, 2020

Overview
To fulfill the requirements of Government Code section 53646, subdivision (b) and the 2020 Annual Investment Policy adopted by CalOptima's Board of Directors on December 5, 2019, the Treasurer submits this quarterly investment report for the period July 1, 2020, through September 30, 2020.

Meketa Investment Group, Inc., completed an independent compliance review of the monthly investment reports prepared by CalOptima's three (3) investment managers: MetLife, Payden & Rygel and Wells Capital. The review found that all investments were compliant with Government Code section 53600 *et seq*., and CalOptima's 2020 Annual Investment Policy.

Portfolio Summary
As of September 30, 2020, the market values of the Short-Term Operating and Restricted Reserve portfolios are as follows:

	Payden & Rygel	MetLife	Wells Capital	Total
Short-Term Operating	$392,087,371	$392,464,899	$392,764,266	$1,177,316,536
Board Designated Reserves				
Tier 1	$160,665,965	$159,458,405	$159,798,287	$479,922,656
Tier 2	--	$107,303,662	--	$107,303,662
Total	$552,753,336	$659,226,966	$552,562,553	$1,764,542,854

Six Month Cash Sufficiency
Based upon a review of forecasted revenues and expenses, CalOptima has sufficient cash on-hand plus projected revenues to meet its operating requirements for the next six (6) months.

Investments Compared to Reserve Policy
In accordance with CalOptima Policy GA.3001: Board-designated Reserve Funds, CalOptima shall maintain a minimum reserve level of one point four (1.4) months and a maximum of two (2) months in consolidated capitation revenues. The following provides a comparison of investments to the minimum and maximum level of Board-designated reserve funds as of September 30, 2020, demonstrating funds in excess to satisfy minimum requirements.

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A) Board-designated Reserve Fund *(CalOptima Policy GA.3001)*

Reserve Name	Market Value	Benchmark		Variance	
		Low 1.4	*High 2.0*	*Low 1.4*	*High 2.0*
Tier 1 - Payden & Rygel	$160,665,965				
Tier 1 - MetLife	$159,458,405				
Tier 1 - Wells Capital	$159,798,287				
	$479,922,656	$319,097,426	$499,753,563	$160,825,231	($19,830,907)

B) CalOptima's Regulatory Compliance Requirements

Reserve Name	Market Value	Regulatory Compliance Requirements		Variance	
		TNE	*TNE*	*TNE*	*TNE*
Tier 2 – MetLife	$107,303,662	$102,433,561	$102,433,561	$4,870,100	$4,870,100
Consolidated:	**$587,226,318**	**$421,530,987**	**$602,187,124**	**$165,695,331**	**($14,960,806)**
Compliance Level	***1.95***	***1.40***	***2.00***	**-**	**-**

CalOptima continues to meet the minimum level of Board-designated reserve funds with a surplus of $165,695,331 as of September 30, 2020. At the end of September 2020, CalOptima's Board-designated reserve compliance level was 1.95.

Update on Fund Transfers
Pursuant to CalOptima Policy GA.3001: Board-designated Reserve Funds, CalOptima will monitor liquidity requirements for the next twelve (12) months and will transfer funds from Short-Term Operating to Board-designated reserves, if necessary.

Fiscal Year (FY) 2020-21 Cash Flow Forecast
DHCS will transition the Medi-Cal pharmacy benefit from managed care plans to the fee-for-service (FFS) program effective January 1, 2021. The annual impact to CalOptima's cash inflow and outflow will be approximately $600 million. The estimated impact for six (6) months in FY 2020-21 is about $300 million.

Attachment
Quarterly Investment Report – July 1, 2020, through September 30, 2020

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MEKETA
INVESTMENT GROUP

CalOptima

Meeting Materials

October 19, 2020

Fund Evaluation Report

Agenda

1. Corporate Update
2. 3Q20 Review
3. Quarterly Investment Report Supplement
4. Custom Peer Group
5. Performance Attribution
6. Appendices
    - Characteristics
    - Holdings
    - Economic and Market Update
    - Disclaimer, Glossary, and Notes

Meketa Investment Group
Corporate Update

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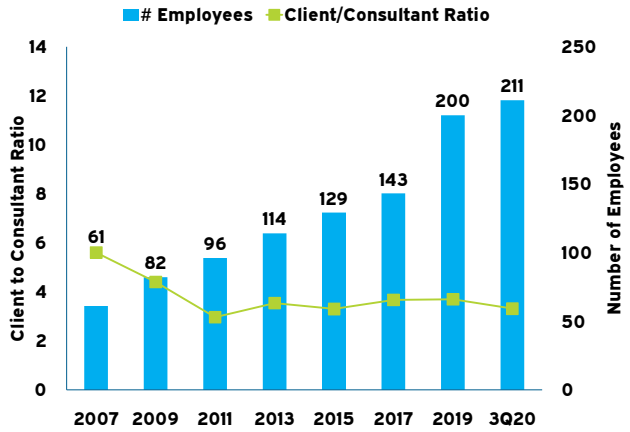
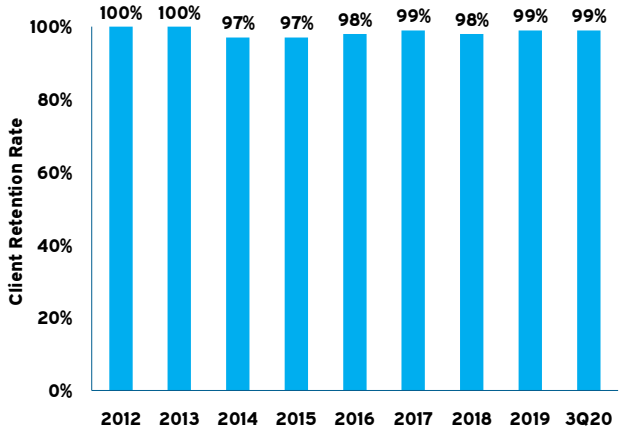
- Staff of 211, including 141 investment professionals and 41 CFA Charterholders
- 215 clients, with over 300 funds throughout the United States
- Significant investment in staff and resources
- Offices in Boston, Chicago, Miami, New York, Portland (OR), San Diego, and London
- We advise on over $1.4 trillion in client assets
  - Over $125 billion in assets committed to alternative investments
    - Private Equity
    - Infrastructure
    - Natural Resources
    - Real Estate
    - Hedge Funds
    - Commodities

Client to Consultant Ratio[1]



Client Retention Rate[2]



Meketa Investment Group is proud to work for over 5 million American families everyday.

[1] On March 15, 2019, 31 employees joined the firm as part of the merger of Meketa Investment Group and Pension Consulting Alliance.
[2] Client Retention Rate is one minus the number of clients lost divided by the number of clients at prior year-end.

Asset Classes Followed Intensively by Meketa Investment Group

Domestic Equities

- Passive
- Enhanced Index
- Large Cap
- Midcap
- Small Cap
- Microcap
- 130/30

International Equities

- Large Cap Developed
- Small Cap Developed
- Emerging Markets
- Frontier Markets

Private Equity

- Buyouts
- Venture Capital
- Private Debt
- Special Situations
- Secondaries
- Fund of Funds

Real Assets

- Public REITs
- Core Real Estate
- Value Added Real Estate
- Opportunistic Real Estate
- Infrastructure
- Timber
- Natural Resources
- Commodities

Fixed Income

- Short-Term
- Core
- Core Plus
- TIPS
- High Yield
- Bank Loans
- Distressed
- Global
- Emerging Markets

Hedge Funds

- Long/Short Equity
- Event Driven
- Relative Value
- Fixed Income Arbitrage
- Multi Strategy
- Market Neutral
- Global Macro
- Fund of Funds
- Portable Alpha

3Q20 Review

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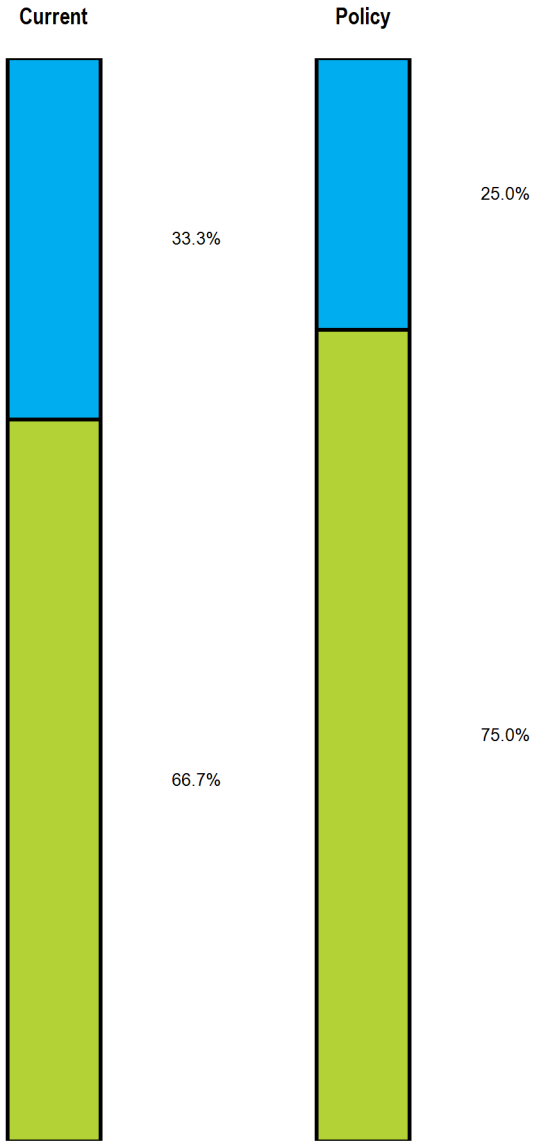


Allocation vs. Targets and Policy	Current Balance	Current Allocation
Fixed Income	$587,226,318	33%
Cash	$1,177,316,536	67%
Total	**$1,764,542,854**	**100%**

Asset Allocation History
5 Years Ending September 30, 2020



Asset Class Performance Summary

	Market Value ($)	% of Portfolio	QTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Total Fund(Gross)	**1,764,542,854**	**100.000**	**0.220**	**2.486**	**2.399**	**1.785**	**--**	**1.578**	**Oct-14**
Total Fund(Net)			**0.199**	**2.401**	**2.315**	**1.705**	**--**	**1.494**	
Fixed Income(Gross)	**587,226,318**	**33.279**	**0.401**	**4.140**	**3.018**	**2.236**	**--**	**2.084**	**Oct-14**
Fixed Income(Net)			**0.379**	**4.049**	**2.931**	**2.151**	**--**	**2.021**	
ICE BofA 1-3 Yrs US Treasuries TR			*0.104*	*3.576*	*2.645*	*1.806*	*1.278*	*1.698*	*Oct-14*
Cash(Gross)	**1,177,316,536**	**66.721**	**0.124**	**1.541**	**1.966**	**1.497**	**0.822**	**1.959**	**Jul-99**
Cash(Net)			**0.104**	**1.459**	**1.884**	**1.418**	**0.720**	**--**	
FTSE T-Bill 3 Months TR			*0.032*	*1.020*	*1.650*	*1.156*	*0.605*	*1.733*	*Jul-99*

Trailing Period Performance

	Market Value ($)	% of Portfolio	% of Sector	QTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Total Fund(Gross)	**1,764,542,854**	**100.000**	**--**	**0.220**	**2.486**	**2.399**	**1.785**	**--**	**1.578**	**Oct-14**
Fixed Income(Gross)	**587,226,318**	**33.279**	**33.279**	**0.401**	**4.140**	**3.018**	**2.236**	**--**	**2.084**	**Oct-14**
ICE BofA 1-3 Yrs US Treasuries TR				*0.104*	*3.576*	*2.645*	*1.806*	*1.278*	*1.698*	*Oct-14*
Tier One: Payden Low Duration(Gross)	160,665,965	9.105	27.360	0.344	3.948	3.062	2.249	1.575	3.052	Jul-99
Tier One: Payden Low Duration(Net)				0.323	3.864	2.983	2.172	1.473	--	
ICE BofA 1-3 Yrs US Treasuries TR				*0.104*	*3.576*	*2.645*	*1.806*	*1.278*	*2.905*	*Jul-99*
ICE BofA 1-3 Yrs US Corp & Govt TR				*0.274*	*3.735*	*2.877*	*2.116*	*1.605*	*3.227*	*Jul-99*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR				*0.174*	*3.675*	*2.788*	*1.988*	*1.485*	*3.117*	*Jul-99*
Tier One: MetLife STAMP 1-3 Year(Gross)	159,458,405	9.037	27.155	0.389	3.966	2.863	--	--	2.227	May-16
Tier One: MetLife STAMP 1-3 Year(Net)				0.368	3.881	2.785	--	--	2.147	
ICE BofA 1-3 Yrs US Treasuries TR				*0.104*	*3.576*	*2.645*	*1.806*	*1.278*	*1.932*	*May-16*
ICE BofA 1-3 Yrs US Corp & Govt TR				*0.274*	*3.735*	*2.877*	*2.116*	*1.605*	*2.223*	*May-16*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR				*0.174*	*3.675*	*2.788*	*1.988*	*1.485*	*2.104*	*May-16*
Tier One: Wells Capital Reserve Account(Gross)	159,798,287	9.056	27.212	0.345	3.880	2.945	--	--	2.277	May-16
Tier One: Wells Capital Reserve Account(Net)				0.327	3.800	2.867	--	--	2.202	
ICE BofA 1-3 Yrs US Treasuries TR				*0.104*	*3.576*	*2.645*	*1.806*	*1.278*	*1.932*	*May-16*
ICE BofA 1-3 Yrs US Corp & Govt TR				*0.274*	*3.735*	*2.877*	*2.116*	*1.605*	*2.223*	*May-16*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR				*0.174*	*3.675*	*2.788*	*1.988*	*1.485*	*2.104*	*May-16*
Tier Two: MetLife STAMP 1-5 Year(Gross)	107,303,662	6.081	18.273	0.587	5.086	3.296	2.521	--	2.119	Apr-13
Tier Two: MetLife STAMP 1-5 Year(Net)				0.555	4.955	3.167	2.394	--	1.992	
ICE BofA 1-5 Yrs US Treasuries TR				*0.126*	*4.597*	*3.182*	*2.193*	*1.718*	*1.799*	*Apr-13*
ICE BofA 1-5 Yrs US Corp & Govt TR				*0.423*	*4.821*	*3.481*	*2.607*	*2.142*	*2.152*	*Apr-13*
ICE BofA 1-5 Yrs AAA-A US Corp & Govt TR				*0.239*	*4.729*	*3.344*	*2.416*	*1.962*	*1.998*	*Apr-13*

Total Fund | As of September 30, 2020

	Market Value ($)	% of Portfolio	% of Sector	QTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Cash(Gross)	**1,177,316,536**	**66.721**	**66.721**	**0.124**	**1.541**	**1.966**	**1.497**	**0.822**	**1.959**	**Jul-99**
FTSE T-Bill 3 Months TR				*0.032*	*1.020*	*1.650*	*1.156*	*0.605*	*1.733*	*Jul-99*
Operating: Payden Enhanced Cash(Gross)	392,087,371	22.220	33.303	0.114	1.587	1.995	1.542	0.844	1.970	Jul-99
Operating: Payden Enhanced Cash(Net)				0.094	1.503	1.911	1.462	0.742	--	
FTSE T-Bill 3 Months TR				*0.032*	*1.020*	*1.650*	*1.156*	*0.605*	*1.733*	*Jul-99*
Operating: MetLife Enhanced Cash(Gross)	392,464,899	22.242	33.336	0.131	1.466	1.964	--	--	1.628	May-16
Operating: MetLife Enhanced Cash(Net)				0.110	1.381	1.879	--	--	1.543	
FTSE T-Bill 3 Months TR				*0.032*	*1.020*	*1.650*	*1.156*	*0.605*	*1.289*	*May-16*
Operating: Wells Capital Enhanced Cash(Gross)	392,764,266	22.259	33.361	0.127	1.552	1.943	--	--	1.604	Jun-16
Operating: Wells Capital Enhanced Cash(Net)				0.109	1.475	1.867	--	--	1.530	
FTSE T-Bill 3 Months TR				*0.032*	*1.020*	*1.650*	*1.156*	*0.605*	*1.309*	*Jun-16*

Asset Class Performance Summary	Fiscal 2020 (%)	Fiscal 2019 (%)	Fiscal 2018 (%)	Fiscal 2017 (%)	Fiscal 2016 (%)	Fiscal 2015 (%)	Fiscal 2014 (%)	Fiscal 2013 (%)
Total Fund(Gross)	**2.901**	**3.191**	**1.221**	**0.754**	**0.842**	**--**	**--**	**--**
Total Fund(Net)	**2.815**	**3.107**	**1.147**	**0.666**	**0.778**	**--**	**--**	**--**
Fixed Income(Gross)	**4.416**	**4.064**	**0.582**	**0.427**	**1.775**	**--**	**--**	**--**
Fixed Income(Net)	**4.324**	**3.982**	**0.495**	**0.336**	**1.699**	**--**	**--**	**--**
ICE BofA 1-3 Yrs US Treasuries TR	*4.071*	*3.974*	*0.079*	*-0.108*	*1.307*	*0.876*	*0.765*	*0.328*
Cash(Gross)	**2.022**	**2.573**	**1.492**	**0.858**	**0.509**	**0.166**	**0.131**	**0.112**
Cash(Net)	**1.940**	**2.489**	**1.427**	**0.758**	**0.446**	**0.058**	**0.018**	**-0.023**
FTSE T-Bill 3 Months TR	*1.558*	*2.294*	*1.325*	*0.455*	*0.138*	*0.021*	*0.038*	*0.079*

Trailing Period Performance	Fiscal 2020 (%)	Fiscal 2019 (%)	Fiscal 2018 (%)	Fiscal 2017 (%)	Fiscal 2016 (%)	Fiscal 2015 (%)	Fiscal 2014 (%)	Fiscal 2013 (%)
Total Fund(Gross)	**2.901**	**3.191**	**1.221**	**0.754**	**0.842**	--	--	--
Fixed Income(Gross)	**4.416**	**4.064**	**0.582**	**0.427**	**1.775**	--	--	--
ICE BofA 1-3 Yrs US Treasuries TR	*4.071*	*3.974*	*0.079*	*-0.108*	*1.307*	*0.876*	*0.765*	*0.328*
Tier One: Payden Low Duration(Gross)	4.313	4.239	0.695	0.583	1.461	0.893	1.048	0.534
Tier One: Payden Low Duration(Net)	4.230	4.167	0.615	0.508	1.388	0.783	0.933	0.399
ICE BofA 1-3 Yrs US Treasuries TR	*4.071*	*3.974*	*0.079*	*-0.108*	*1.307*	*0.876*	*0.765*	*0.328*
ICE BofA 1-3 Yrs US Corp & Govt TR	*4.185*	*4.302*	*0.265*	*0.336*	*1.581*	*0.901*	*1.246*	*0.861*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*4.175*	*4.170*	*0.198*	*0.147*	*1.492*	*0.906*	*1.038*	*0.656*
Tier One: MetLife STAMP 1-3 Year(Gross)	4.192	3.544	0.842	0.478	--	--	--	--
Tier One: MetLife STAMP 1-3 Year(Net)	4.108	3.478	0.761	0.395	--	--	--	--
ICE BofA 1-3 Yrs US Treasuries TR	*4.071*	*3.974*	*0.079*	*-0.108*	*1.307*	*0.876*	*0.765*	*0.328*
ICE BofA 1-3 Yrs US Corp & Govt TR	*4.185*	*4.302*	*0.265*	*0.336*	*1.581*	*0.901*	*1.246*	*0.861*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*4.175*	*4.170*	*0.198*	*0.147*	*1.492*	*0.906*	*1.038*	*0.656*
Tier One: Wells Capital Reserve Account(Gross)	4.236	4.223	0.425	0.403	--	--	--	--
Tier One: Wells Capital Reserve Account(Net)	4.153	4.145	0.353	0.330	--	--	--	--
ICE BofA 1-3 Yrs US Treasuries TR	*4.071*	*3.974*	*0.079*	*-0.108*	*1.307*	*0.876*	*0.765*	*0.328*
ICE BofA 1-3 Yrs US Corp & Govt TR	*4.185*	*4.302*	*0.265*	*0.336*	*1.581*	*0.901*	*1.246*	*0.861*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*4.175*	*4.170*	*0.198*	*0.147*	*1.492*	*0.906*	*1.038*	*0.656*
Tier Two: MetLife STAMP 1-5 Year(Gross)	5.177	4.347	0.258	0.140	3.021	1.494	2.095	--
Tier Two: MetLife STAMP 1-5 Year(Net)	5.048	4.217	0.131	0.016	2.894	1.367	1.969	--
ICE BofA 1-5 Yrs US Treasuries TR	*5.254*	*4.903*	*-0.351*	*-0.532*	*2.426*	*1.376*	*1.157*	*-0.027*
ICE BofA 1-5 Yrs US Corp & Govt TR	*5.332*	*5.384*	*-0.156*	*0.134*	*2.649*	*1.344*	*2.000*	*0.718*
ICE BofA 1-5 Yrs AAA-A US Corp & Govt TR	*5.350*	*5.143*	*-0.220*	*-0.172*	*2.570*	*1.376*	*1.641*	*0.409*

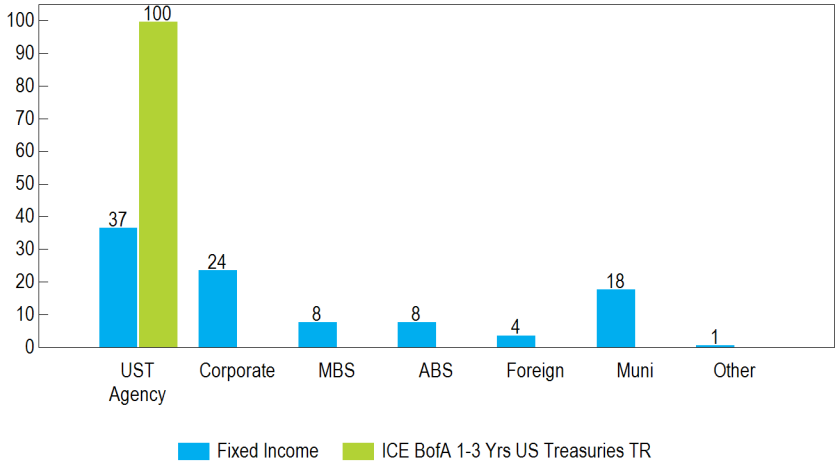
Total Fund | As of September 30, 2020

	Fiscal 2020 (%)	Fiscal 2019 (%)	Fiscal 2018 (%)	Fiscal 2017 (%)	Fiscal 2016 (%)	Fiscal 2015 (%)	Fiscal 2014 (%)	Fiscal 2013 (%)
Cash(Gross)	**2.022**	**2.573**	**1.492**	**0.858**	**0.509**	**0.166**	**0.131**	**0.112**
FTSE T-Bill 3 Months TR	*1.558*	*2.294*	*1.325*	*0.455*	*0.138*	*0.021*	*0.038*	*0.079*
Operating: Payden Enhanced Cash(Gross)	2.049	2.597	1.580	0.887	0.573	0.166	0.131	0.112
Operating: Payden Enhanced Cash(Net)	1.965	2.508	1.500	0.812	0.505	0.058	0.018	-0.023
FTSE T-Bill 3 Months TR	*1.558*	*2.294*	*1.325*	*0.455*	*0.138*	*0.021*	*0.038*	*0.079*
Operating: MetLife Enhanced Cash(Gross)	1.967	2.605	1.501	0.898	--	--	--	--
Operating: MetLife Enhanced Cash(Net)	1.881	2.519	1.416	0.814	--	--	--	--
FTSE T-Bill 3 Months TR	*1.558*	*2.294*	*1.325*	*0.455*	*0.138*	*0.021*	*0.038*	*0.079*
Operating: Wells Capital Enhanced Cash(Gross)	2.030	2.550	1.443	0.721	--	--	--	--
Operating: Wells Capital Enhanced Cash(Net)	1.953	2.474	1.370	0.649	--	--	--	--
FTSE T-Bill 3 Months TR	*1.558*	*2.294*	*1.325*	*0.455*	*0.138*	*0.021*	*0.038*	*0.079*

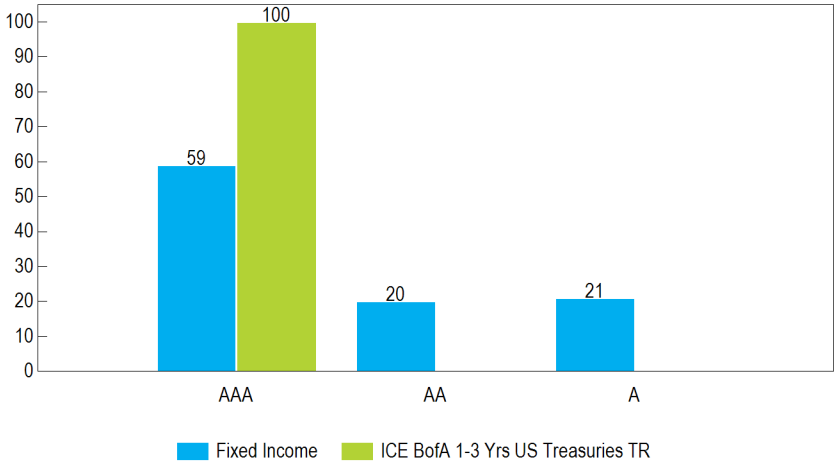
Asset Allocation on September 30, 2020	Actual	Actual
Tier One: Payden Low Duration	$160,665,965	27.4%
Tier One: MetLife STAMP 1-3 Year	$159,458,405	27.2%
Tier One: Wells Capital Reserve Account	$159,798,287	27.2%
Tier Two: MetLife STAMP 1-5 Year	$107,303,662	18.3%
Total	**$587,226,318**	**100.0%**

Fixed Income Characteristics vs. ICE BofA 1-3 Yrs US Treasuries TR	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.4	0.1	0.5
Average Duration	1.9	1.9	1.9
Average Quality	AA	AAA	AA

Sector Allocation



Credit Quality Allocation



Allocation weights may not add to 100% due to rounding.

Tier One: Payden Low Duration | As of September 30, 2020

Account Information

Account Name	**Tier One: Payden Low Duration**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**7/01/99**
Account Type	**US Fixed Income Short Term**
Benchmark	**ICE BofA 1-3 Yrs US Treasuries TR**
Universe	**eV US Short Duration Fixed Inc Net**

Portfolio Performance Summary

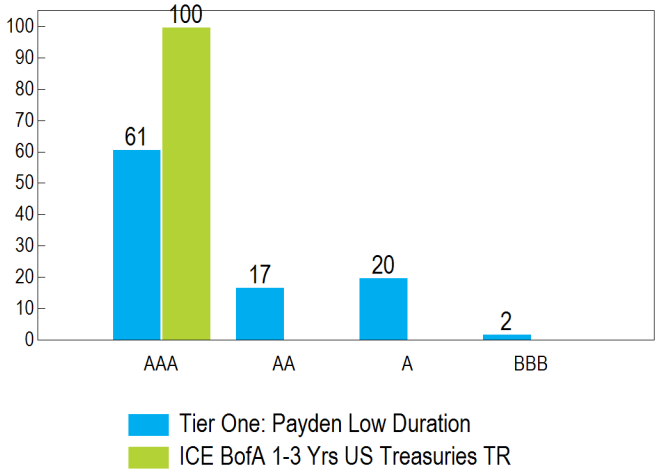
	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Tier One: Payden Low Duration(Gross)	0.344	3.369	3.948	3.062	2.249	1.575	3.052	Jul-99
Tier One: Payden Low Duration(Net)	0.323	3.306	3.864	2.983	2.172	1.473	--	
ICE BofA 1-3 Yrs US Treasuries TR	*0.104*	*3.051*	*3.576*	*2.645*	*1.806*	*1.278*	*2.905*	*Jul-99*
ICE BofA 1-3 Yrs US Corp & Govt TR	*0.274*	*3.110*	*3.735*	*2.877*	*2.116*	*1.605*	*3.227*	*Jul-99*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*0.174*	*3.103*	*3.675*	*2.788*	*1.988*	*1.485*	*3.117*	*Jul-99*

Tier One: Payden Low Duration Fixed Income Characteristics vs. ICE BofA 1-3 Yrs US Treasuries TR

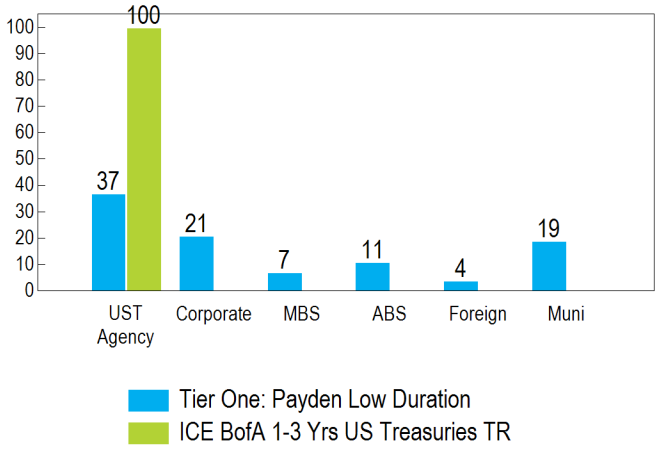
	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.41	0.13	0.55
Average Duration	1.89	1.90	1.89
Average Quality	AA	AAA	AA

Allocation weights may not add to 100% due to rounding.

Credit Quality Allocation



US Sector Allocation



Tier One: Wells Capital Reserve Account | As of September 30, 2020

Account Information

Account Name	**Tier One: Wells Capital Reserve Account**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**5/01/16**
Account Type	**US Fixed Income Short Term**
Benchmark	**ICE BofA 1-3 Yrs US Treasuries TR**
Universe	**eV US Short Duration Fixed Inc Net**

Portfolio Performance Summary

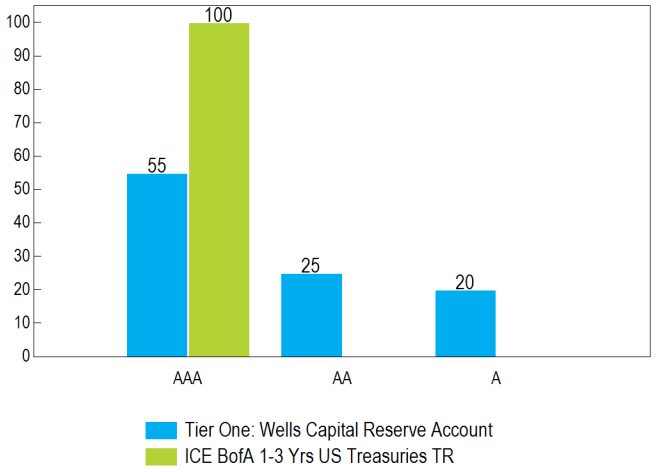
	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Tier One: Wells Capital Reserve Account(Gross)	0.345	3.289	3.880	2.945	--	--	2.277	May-16
Tier One: Wells Capital Reserve Account(Net)	0.327	3.230	3.800	2.867	--	--	2.202	
ICE BofA 1-3 Yrs US Treasuries TR	*0.104*	*3.051*	*3.576*	*2.645*	*1.806*	*1.278*	*1.932*	*May-16*
ICE BofA 1-3 Yrs US Corp & Govt TR	*0.274*	*3.110*	*3.735*	*2.877*	*2.116*	*1.605*	*2.223*	*May-16*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*0.174*	*3.103*	*3.675*	*2.788*	*1.988*	*1.485*	*2.104*	*May-16*

Tier One: Wells Capital Reserve Account Fixed Income Characteristics vs. ICE BofA 1-3 Yrs US Treasuries TR

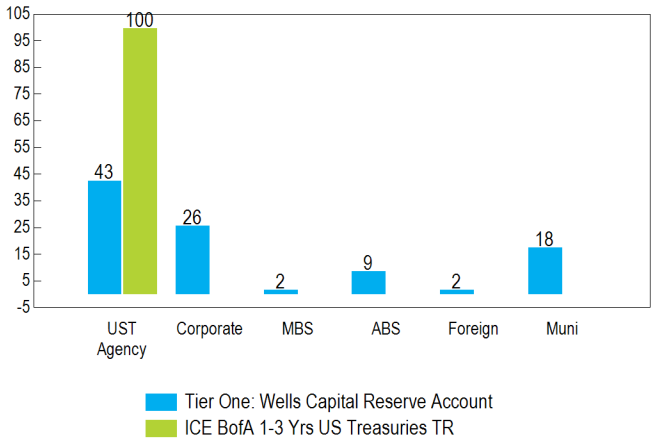
	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.31	0.13	0.48
Average Duration	1.70	1.90	1.67
Average Quality	AA	AAA	AA

Allocation weights may not add to 100% due to rounding.

Credit Quality Allocation



US Sector Allocation



Tier One: MetLife STAMP 1-3 Year | As of September 30, 2020

Account Information

Account Name	**Tier One: MetLife STAMP 1-3 Year**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**5/01/16**
Account Type	**US Fixed Income Short Term**
Benchmark	**ICE BofA 1-3 Yrs US Treasuries TR**
Universe	**eV US Short Duration Fixed Inc Net**

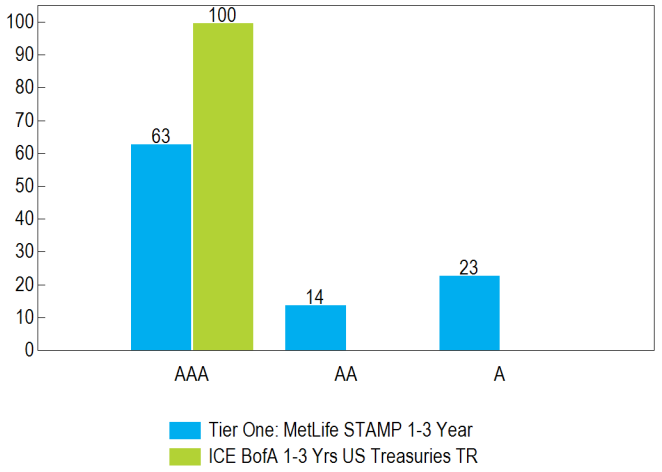
Portfolio Performance Summary

	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Tier One: MetLife STAMP 1-3 Year(Gross)	0.389	3.345	3.966	2.863	--	--	2.227	May-16
Tier One: MetLife STAMP 1-3 Year(Net)	0.368	3.281	3.881	2.785	--	--	2.147	
ICE BofA 1-3 Yrs US Treasuries TR	*0.104*	*3.051*	*3.576*	*2.645*	*1.806*	*1.278*	*1.932*	*May-16*
ICE BofA 1-3 Yrs US Corp & Govt TR	*0.274*	*3.110*	*3.735*	*2.877*	*2.116*	*1.605*	*2.223*	*May-16*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*0.174*	*3.103*	*3.675*	*2.788*	*1.988*	*1.485*	*2.104*	*May-16*

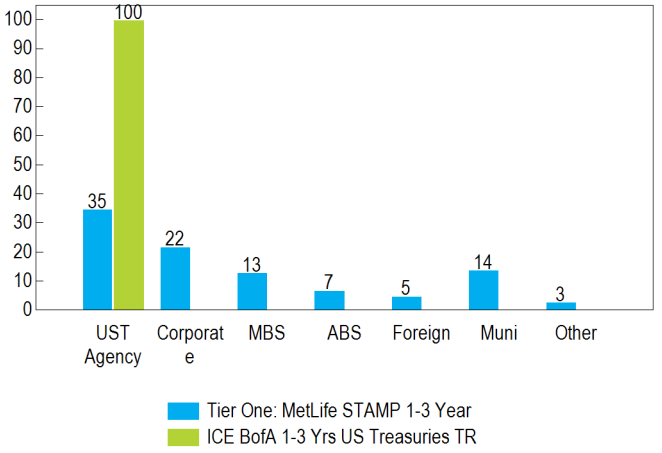
Tier One: MetLife STAMP 1-3 Year Fixed Income Characteristics vs. ICE BofA 1-3 Yrs US Treasuries TR

	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.44	0.13	0.52
Average Duration	1.58	1.90	1.59
Average Quality	AA	AAA	AA

Credit Quality Allocation



US Sector Allocation



Allocation weights may not add to 100% due to rounding.

Tier Two: MetLife STAMP 1-5 Year | As of September 30, 2020

Account Information

Account Name	**Tier Two: MetLife STAMP 1-5 Year**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**4/01/13**
Account Type	**US Fixed Income Short Term**
Benchmark	**ICE BofA 1-5 Yrs US Treasuries TR**
Universe	**eV US Short Duration Fixed Inc Net**

Portfolio Performance Summary

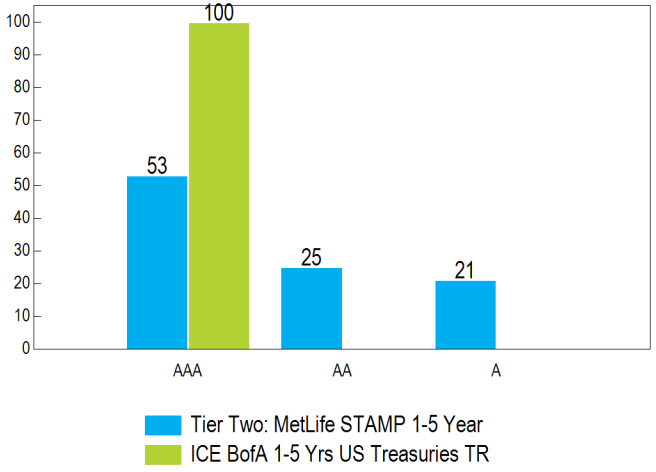
	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Tier Two: MetLife STAMP 1-5 Year(Gross)	0.587	4.542	5.086	3.296	2.521	--	2.119	Apr-13
Tier Two: MetLife STAMP 1-5 Year(Net)	0.555	4.444	4.955	3.167	2.394	--	1.992	
ICE BofA 1-5 Yrs US Treasuries TR	*0.126*	*4.231*	*4.597*	*3.182*	*2.193*	*1.718*	*1.799*	*Apr-13*
ICE BofA 1-5 Yrs US Corp & Govt TR	*0.423*	*4.264*	*4.821*	*3.481*	*2.607*	*2.142*	*2.152*	*Apr-13*
ICE BofA 1-5 Yrs AAA-A US Corp & Govt TR	*0.239*	*4.274*	*4.729*	*3.344*	*2.416*	*1.962*	*1.998*	*Apr-13*

Tier Two: MetLife STAMP 1-5 Year Fixed Income Characteristics vs. ICE BofA 1-5 Yrs US Treasuries TR

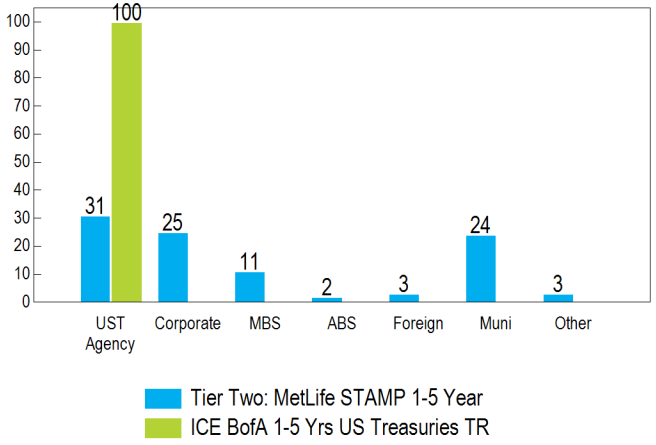
	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.53	0.16	0.61
Average Duration	2.48	2.65	2.53
Average Quality	AA	AAA	AA

Allocation weights may not add to 100% due to rounding.

Credit Quality Allocation



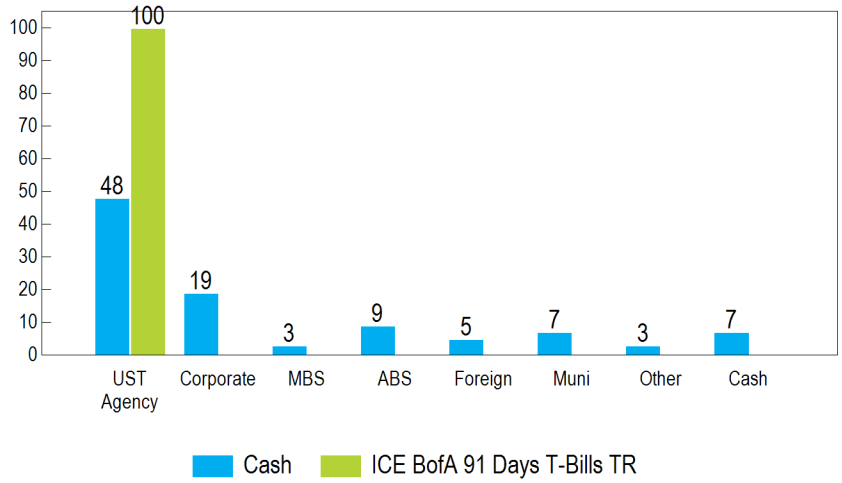
US Sector Allocation



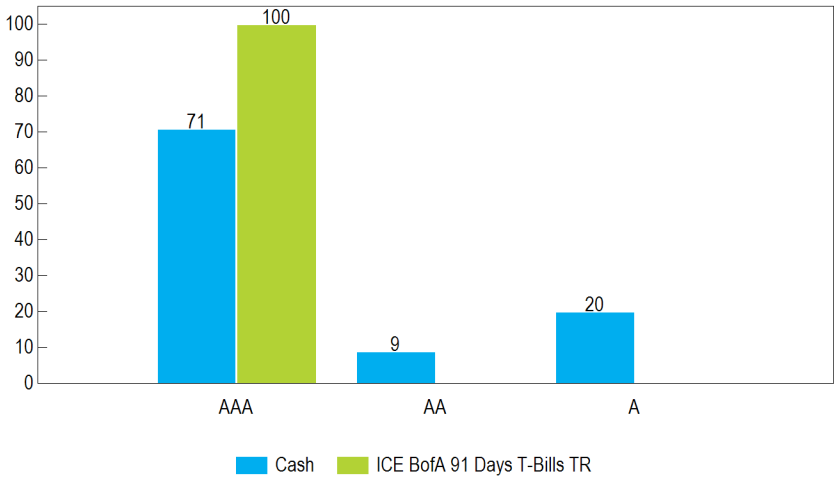
Asset Allocation on September 30, 2020	Actual	Actual
Operating: MetLife Enhanced Cash	$392,464,899	33.3%
Operating: Payden Enhanced Cash	$392,087,371	33.3%
Operating: Wells Capital Enhanced Cash	$392,764,266	33.4%
Total	**$1,177,316,536**	**100.0%**

Cash Characteristics vs. ICE BofA 91 Days T-Bills TR	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.2	0.1	0.3
Average Duration	0.3	0.2	0.2
Average Quality	AA	AAA	AA

Sector Allocation



Credit Quality Allocation



Allocation weights may not add to 100% due to rounding.

Operating: Payden Enhanced Cash | As of September 30, 2020

Account Information

Account Name	**Operating: Payden Enhanced Cash**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**7/01/99**
Account Type	**Cash Alternatives**
Benchmark	**FTSE T-Bill 3 Months TR**
Universe	**eV US Enh Cash Management Net**

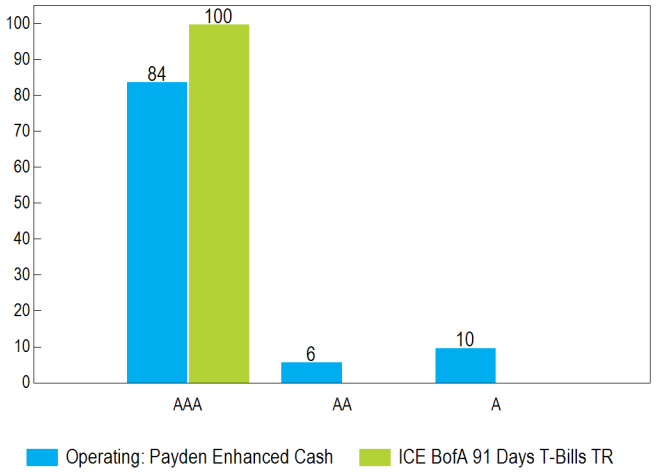
Portfolio Performance Summary

	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Operating: Payden Enhanced Cash(Gross)	0.114	1.082	1.587	1.995	1.542	0.844	1.970	Jul-99
Operating: Payden Enhanced Cash(Net)	0.094	1.020	1.503	1.911	1.462	0.742	--	
FTSE T-Bill 3 Months TR	*0.032*	*0.556*	*1.020*	*1.650*	*1.156*	*0.605*	*1.733*	*Jul-99*

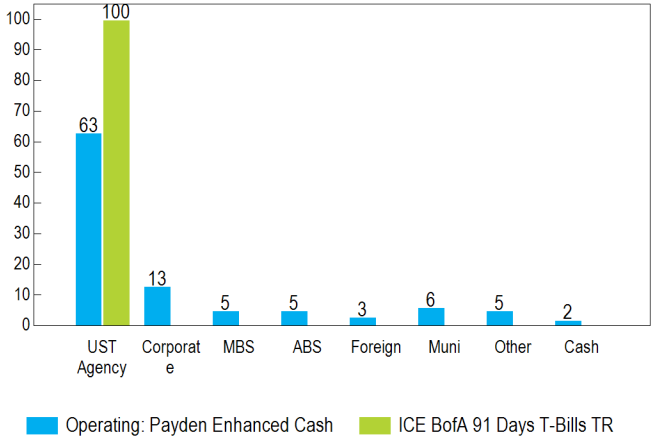
Operating: Payden Enhanced Cash Fixed Income Characteristics vs. ICE BofA 91 Days T-Bills TR

	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.20	0.09	0.26
Average Duration	0.25	0.24	0.12
Average Quality	AA	AAA	AA

Credit Quality Allocation



US Sector Allocation



Allocation weights may not add to 100% due to rounding.

Operating: MetLife Enhanced Cash | As of September 30, 2020

Account Information

Account Name	**Operating: MetLife Enhanced Cash**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**5/02/16**
Account Type	**Cash**
Benchmark	**FTSE T-Bill 3 Months TR**
Universe	**eV US Enh Cash Management Net**

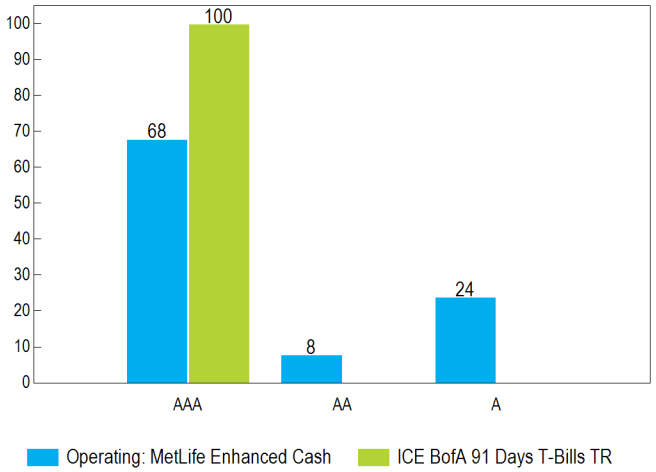
Portfolio Performance Summary

	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Operating: MetLife Enhanced Cash(Gross)	0.131	0.958	1.466	1.964	--	--	1.628	May-16
Operating: MetLife Enhanced Cash(Net)	0.110	0.895	1.381	1.879	--	--	1.543	
FTSE T-Bill 3 Months TR	*0.032*	*0.556*	*1.020*	*1.650*	*1.156*	*0.605*	*1.289*	*May-16*

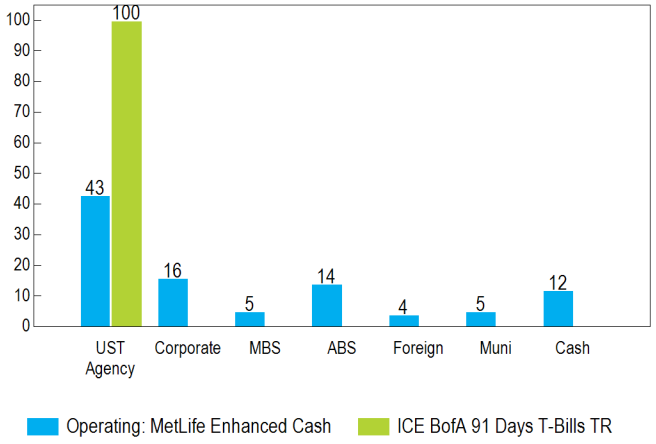
Operating: MetLife Enhanced Cash Fixed Income Characteristics vs. ICE BofA 91 Days T-Bills TR

	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.28	0.09	0.38
Average Duration	0.17	0.24	0.14
Average Quality	AA	AAA	AA

Credit Quality Allocation



US Sector Allocation



Allocation weights may not add to 100% due to rounding.

Operating: Wells Capital Enhanced Cash | As of September 30, 2020

Account Information

Account Name	**Operating: Wells Capital Enhanced Cash**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**6/01/16**
Account Type	**Cash**
Benchmark	**FTSE T-Bill 3 Months TR**
Universe	**eV US Enh Cash Management Net**

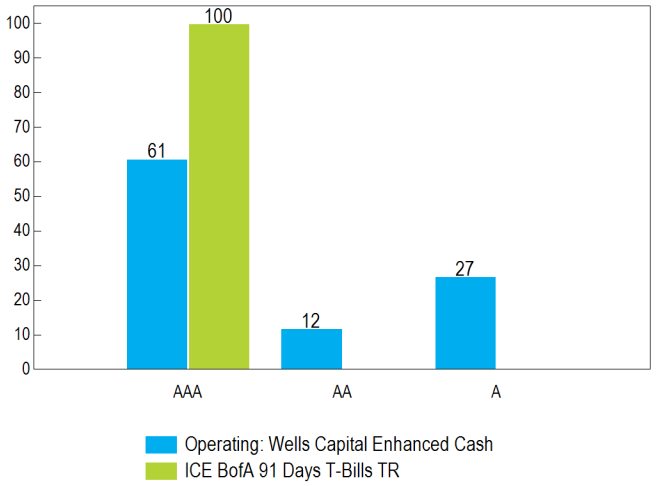
Portfolio Performance Summary

	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Operating: Wells Capital Enhanced Cash(Gross)	0.127	1.012	1.552	1.943	--	--	1.604	Jun-16
Operating: Wells Capital Enhanced Cash(Net)	0.109	0.957	1.475	1.867	--	--	1.530	
FTSE T-Bill 3 Months TR	*0.032*	*0.556*	*1.020*	*1.650*	*1.156*	*0.605*	*1.309*	*Jun-16*

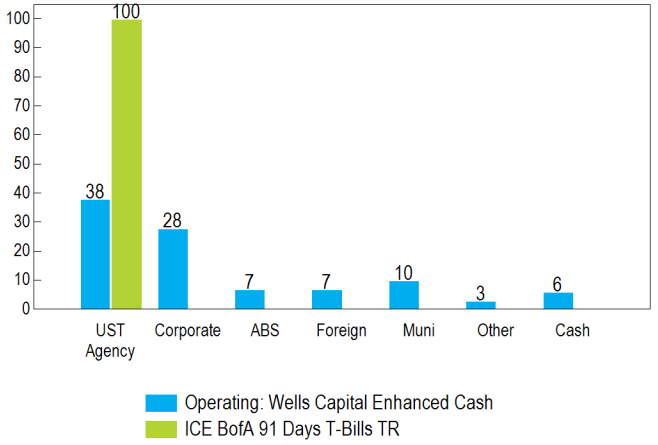
Operating: Wells Capital Enhanced Cash Fixed Income Characteristics vs. ICE BofA 91 Days T-Bills TR

	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.21	0.09	0.33
Average Duration	0.34	0.24	0.44
Average Quality	AA	AAA	AA

Credit Quality Allocation



US Sector Allocation



Allocation weights may not add to 100% due to rounding.

Annual Investment Expense Analysis
As Of September 30, 2020

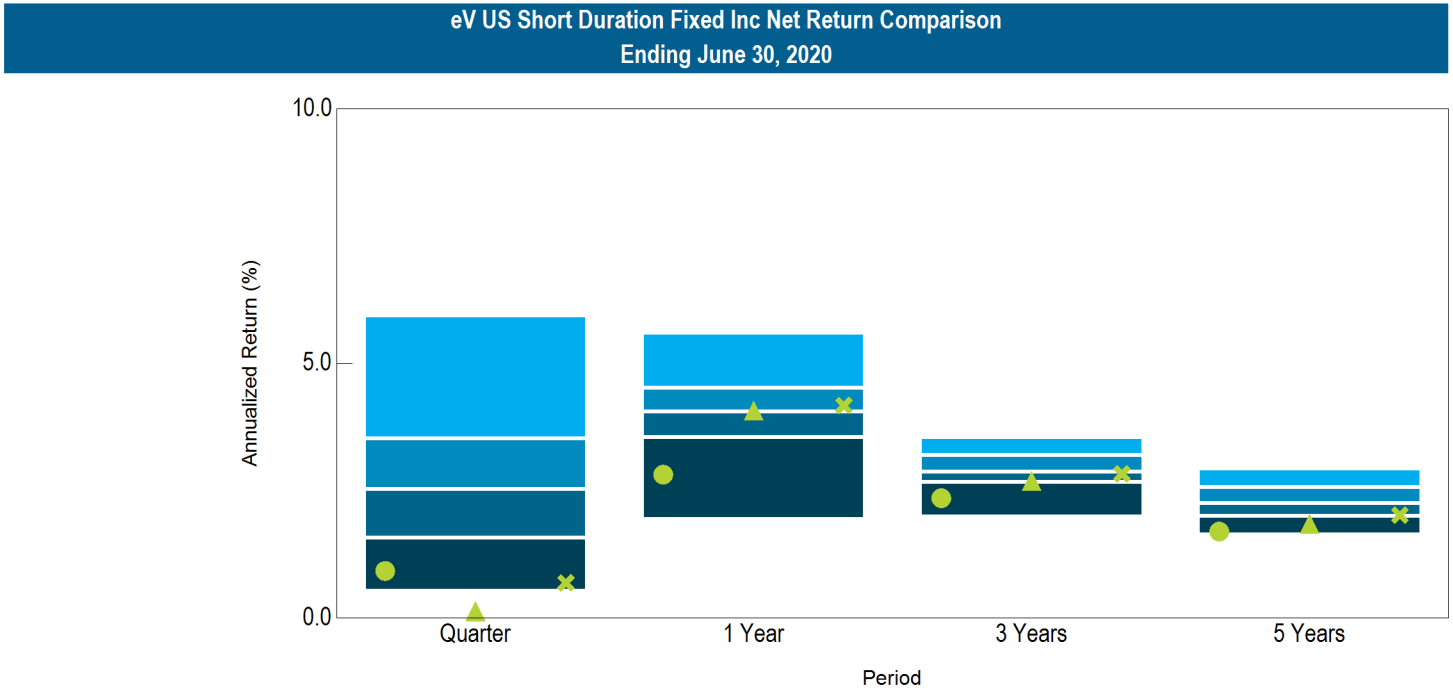
Name	Fee Schedule	Market Value
Fixed Income		**$587,226,318**
Tier One: Payden Low Duration	0.10% of First 100.0 Mil, 0.08% of Next 250.0 Mil, 0.07% Thereafter	$160,665,965
Tier One: MetLife STAMP 1-3 Year	0.10% of First 50.0 Mil, 0.09% of Next 250.0 Mil, 0.07% Thereafter	$159,458,405
Tier One: Wells Capital Reserve Account	0.09% of First 100.0 Mil, 0.07% of Next 200.0 Mil, 0.06% Thereafter	$159,798,287
Tier Two: MetLife STAMP 1-5 Year	0.15% of First 50.0 Mil, 0.10% of Next 250.0 Mil, 0.07% Thereafter	$107,303,662
Cash		**$1,177,316,536**
Operating: Payden Enhanced Cash	0.10% of First 100.0 Mil, 0.08% of Next 250.0 Mil, 0.07% Thereafter	$392,087,371
Operating: MetLife Enhanced Cash	0.10% of First 50.0 Mil, 0.09% of Next 250.0 Mil, 0.07% Thereafter	$392,464,899
Operating: Wells Capital Enhanced Cash	0.09% of First 100.0 Mil, 0.07% of Next 200.0 Mil, 0.06% Thereafter	$392,764,266
Total		**$1,764,542,854**

Please note that MetLife, Payden, and Wells Capital charge their investment management fees on an aggregate basis across Operating Cash,Tier One and Tier Two portfolios.

Statistics Summary 1 Year Ending September 30, 2020	Sharpe Ratio
Fixed Income	3.53
ICE BofA 1-3 Yrs US Treasuries TR	1.83
Tier One: Payden Low Duration	3.33
ICE BofA 1-3 Yrs US Treasuries TR	1.83
Tier One: MetLife STAMP 1-3 Year	3.84
ICE BofA 1-3 Yrs US Treasuries TR	1.83
Tier One: Wells Capital Reserve Account	3.20
ICE BofA 1-3 Yrs US Treasuries TR	1.83
Tier Two: MetLife STAMP 1-5 Year	3.58
ICE BofA 1-5 Yrs US Treasuries TR	1.92
Cash	1.38
FTSE T-Bill 3 Months TR	0.90
Operating: Payden Enhanced Cash	1.63
FTSE T-Bill 3 Months TR	0.90
Operating: MetLife Enhanced Cash	0.72
FTSE T-Bill 3 Months TR	0.90
Operating: Wells Capital Enhanced Cash	2.18
FTSE T-Bill 3 Months TR	0.90

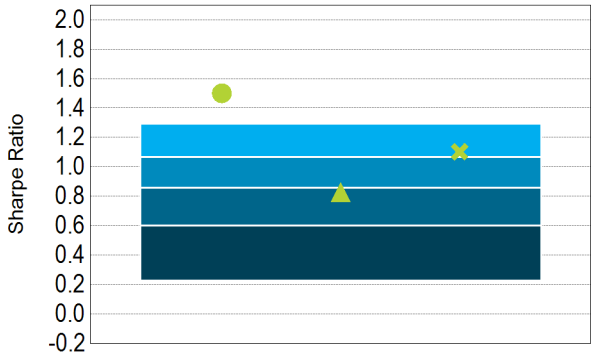
Statistics Summary 3 Years Ending September 30, 2020	Sharpe Ratio
Fixed Income	1.44
ICE BofA 1-3 Yrs US Treasuries TR	0.86
Tier One: Payden Low Duration	1.49
ICE BofA 1-3 Yrs US Treasuries TR	0.86
Tier One: MetLife STAMP 1-3 Year	1.58
ICE BofA 1-3 Yrs US Treasuries TR	0.86
Tier One: Wells Capital Reserve Account	1.32
ICE BofA 1-3 Yrs US Treasuries TR	0.86
Tier Two: MetLife STAMP 1-5 Year	1.31
ICE BofA 1-5 Yrs US Treasuries TR	0.91
Cash	0.98
FTSE T-Bill 3 Months TR	0.34
Operating: Payden Enhanced Cash	1.15
FTSE T-Bill 3 Months TR	0.34
Operating: MetLife Enhanced Cash	0.64
FTSE T-Bill 3 Months TR	0.34
Operating: Wells Capital Enhanced Cash	1.13
FTSE T-Bill 3 Months TR	0.34

Statistics Summary 5 Years Ending September 30, 2020	Sharpe Ratio
Fixed Income	1.13
ICE BofA 1-3 Yrs US Treasuries TR	0.60
Tier One: Payden Low Duration	1.21
ICE BofA 1-3 Yrs US Treasuries TR	0.60
Tier One: MetLife STAMP 1-3 Year	--
ICE BofA 1-3 Yrs US Treasuries TR	0.60
Tier One: Wells Capital Reserve Account	--
ICE BofA 1-3 Yrs US Treasuries TR	0.60
Tier Two: MetLife STAMP 1-5 Year	1.00
ICE BofA 1-5 Yrs US Treasuries TR	0.64
Cash	0.94
FTSE T-Bill 3 Months TR	0.09
Operating: Payden Enhanced Cash	1.14
FTSE T-Bill 3 Months TR	0.09
Operating: MetLife Enhanced Cash	--
FTSE T-Bill 3 Months TR	0.09
Operating: Wells Capital Enhanced Cash	--
FTSE T-Bill 3 Months TR	0.09



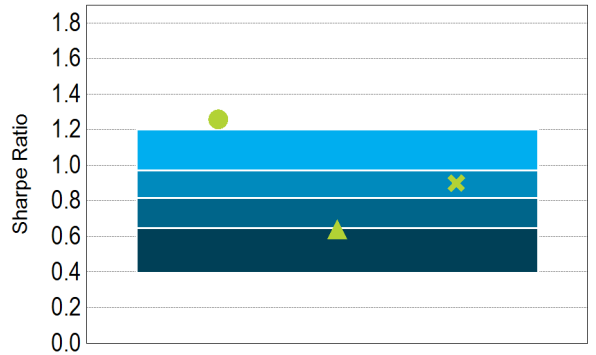
	Return (Rank)							
5th Percentile	5.9		5.6		3.6		2.9	
25th Percentile	3.5		4.5		3.2		2.6	
Median	2.5		4.1		2.9		2.3	
75th Percentile	1.6		3.6		2.7		2.0	
95th Percentile	0.5		1.9		2.0		1.6	
# of Portfolios	143		143		140		129	
● Total Fund	0.9	(89)	2.8	(87)	2.4	(93)	1.7	(93)
▲ ICE BofA 1-3 Yrs US Treasuries TR	0.1	(99)	4.1	(50)	2.7	(74)	1.8	(88)
× ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	0.7	(93)	4.2	(45)	2.8	(58)	2.0	(75)

3 Year Sharpe Ratio as of 6/30/2020
vs. eV US Short Duration Fixed Inc Net



Total Fund	
Value	1.5
Rank	2
ICE BofA 1-3 Yrs US Treasuries TR	
Value	0.8
Rank	52
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	
Value	1.1
Rank	22
Universe	
5th %tile	1.3
25th %tile	1.1
Median	0.9
75th %tile	0.6
95th %tile	0.2

5 Year Sharpe Ratio as of 6/30/2020
vs. eV US Short Duration Fixed Inc Net



Total Fund	
Value	1.3
Rank	4
ICE BofA 1-3 Yrs US Treasuries TR	
Value	0.6
Rank	77
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	
Value	0.9
Rank	40
Universe	
5th %tile	1.2
25th %tile	1.0
Median	0.8
75th %tile	0.7
95th %tile	0.4

[1]Statistics are for the 3-year and 5 -year period ending June 30, 2020

Quarterly Investment Report Supplement

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Annual Investment Policy (2020)

Maturity and Quality Requirements

Allowable Instruments	Maximum Permitted Maturity			Actual Maximum Maturity							Compliance
	Operating Funds	Tier One	Tier Two	Operating Funds			Tier One			Tier Two	
				ML	*P&R*	*WF*	*ML*	*P&R*	*WF*	*ML*	
US Treasuries	2 years	5 years	5 years	N/A	0.94 years	0.56 years	3.54 years	2.96 years	2.96 years	4.92 years	Yes
US Agencies	2 years	5 years	5 years	1.96 years	N/A	0.63 years	4.87 years	3.88 years	2.94 years	4.87 years	Yes
State & Local Obligations[1]	2 years	5 years	5 years	1.09 years	1.09 years	1.62 years	4.17 years	3.84 years	2.92 years	4.84 years	Yes
Supranationals	2 years	5 years	5 years	1.96 years	0.65 years	0.97 years	2.72 years	3.13 years	2.65 years	2.72 years	Yes
Negotiable Cert of Deposit	1 year	1 year	1 year	0.35 years	0.32 years[2]	N/A	N/A	N/A	N/A	N/A	Yes
Commercial Paper	270 days	270 days	270 days	176 days	N/A	54 days	N/A	N/A	N/A	N/A	Yes
Repurchase Agreements	30 days	30 days	30 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Medium Term Notes	2 years	5 years	5 years	0.63 years	1.55 years	1.63 years	2.96 years	4.42 years	2.86 years	4.62 years	Yes
Mortgage/ Asset-Backed	2 years	5 years	5 years	1.21 years	0.58 years[3]	1.47 years	4.96 years	3.19 years	4.13 years	4.71 years	Yes
Variable & Floating Rate	2 years	5 years	5 years	0.21 years	1.00 years	0.63 years	3.07 years	2.96 years	N/A	3.07 years	Yes
Manager Confirmed Adherence to 5% Issuer Limit				**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

- Investment Managers have independently verified that they have maintained compliance with CalOptima's Investment Policy Statement-designated security credit rating requirements during the review quarter.

[1] Includes CA and any other state in the US.

[2] FRN CDs included in Variable & Floating Rate Securities section totaling 1.81% of the combined portfolio.

[3] MBS & ABS minimum for security rating AA-, minimum issuer rating A- despite Code change 1/2019.

Annual Investment Policy (2020)

Diversification Compliance[1]

Allowable Instruments	Maximum (%)	MetLife (%)	MetLife ($ mm)	Payden (%)	Payden ($ mm)	Wells Capital (%)	Wells Capital ($ mm)	Total (%)	Total ($ mm)
US Treasuries	100	9.6	63.2	44.0	243.0	10.8	59.9	20.7	366.0
US Agencies	100	6.3	41.5	2.4	13.1	28.7	158.6	12.1	213.2
State & Local Obligations[2]	30	10.5	69.2	11.1	61.3	12.5	68.9	11.3	199.3
Supranationals	30	4.3	28.3	1.9	10.2	5.8	32.3	4.0	70.8
Negotiable Certificate of Deposit	30	6.0	39.5	1.9	10.6	0.0	0.0	2.8	50.1
Commercial Paper	25	1.2	8.0	0.0	0.0	2.4	13.0	1.2	21.0
Repurchase Agreements	100	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medium Term Notes	30	9.3	61.3	8.2	45.2	21.0	116.0	12.6	222.5
Money Market Funds	20	24.1	158.6	1.1	5.8	4.0	22.3	10.6	186.8
Mortgage/Asset-Backed	20	15.0	98.6	9.5	52.5	6.0	33.3	10.4	184.3
Variable & Floating Rate	30	13.8	91.0	20.1	111.1	8.7	48.3	14.2	250.5
Total		**100.0**	**659.2**	**100.0**	**552.8**	**100.0**	**552.6**	**100.0**	**1764.5**

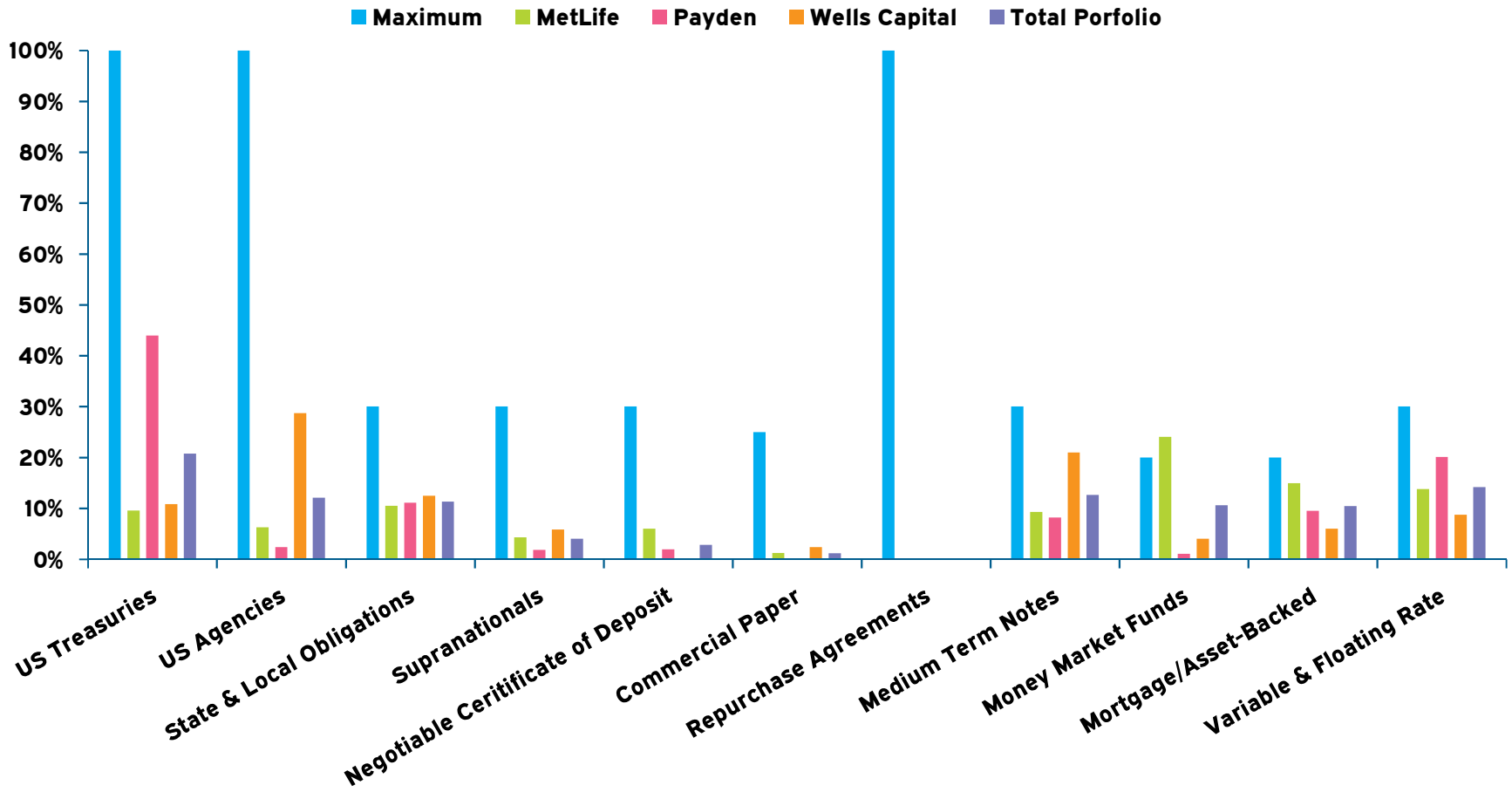
- Investment composition of each portfolio and the total portfolio are in compliance with the CalOptima Annual Investment Policy 2020.

[1] Blended allocations for Payden & Rygel, MetLife, and Wells Capital accounts.

[2] Includes CA and any other state in the US.

Annual Investment Policy (2020)

Actual vs. Diversity Requirements
As of September 30, 2020



Custom Peer Group

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Custom Peer Group

- Given CalOptima's unique investment guidelines, traditional fixed income peer groups are not the best comparison tool for the Tier One and Tier Two pools.
- Meketa Investment Group surveyed the eVestment Alliance US Short Duration Fixed Income universe and Morningstar's Short Duration Fixed Income universe to create custom peer universes for each of the Tier One and Tier Two pools in order to provide a more accurate performance comparison.[1]
  - For the analysis, the combined eVestment and Morningstar universe was pared down through the elimination of funds with exposure to securities with below-"A"-rated credit.
  - Two unique buckets were established based on each portfolio's historical average effective duration relative to the ICE BofA Merrill Lynch 1-3 Year Treasury index (Tier One peer group) and the ICE BofA Merrill Lynch 1-5 year Treasury index (Tier Two peer group).
  - The Tier One peer group consists of fourteen strategies with a median effective duration of 1.79 years, while the Tier Two peer group consists of eight strategies with a median effective duration of 2.28 years as of June 30, 2020.
- Please note that the analysis is as of June 30, 2020, as the universe of investment managers that had reported data as of September 30, 2020 was very small at the date that these materials were submitted.
- This analysis is based on a small peer universe that may change significantly over time, potentially resulting in large changes in peer rankings quarter-to-quarter.

[1] Though this comparison is more accurate than ranking the managers relative to the broad short duration peer group, these peer managers are not subject to the restrictions of the California Government Code. They are likely to have more degrees of freedom to invest across fixed income securities and sectors.

Custom Peer Group: MetLife Tier One

Gross of Fees Returns as of 6/30/2020[1]	2Q 2020 (%)	1 Year (%)	3 Years (%)	Since Inception[2] (%)
Tier One: MetLife STAMP 1-3 Year	1.25	4.19	2.85	2.27
Peer Group Median Return	1.63	4.20	2.95	2.44
Peer Group Rank (percentile)	67	51	63	71

Standard Deviation as of 6/30/2020[3]	3 Years (%)
Tier One: MetLife STAMP 1-3 Year	0.77
Median Standard Deviation	1.10
Peer Group Rank (percentile)	6

- The MetLife Tier One portfolio slightly underperformed the peer group over the trailing quarter as well as one-, three-year and since inception time periods.
- Standard deviation has ranked very favorably versus peers over the trailing three-year period.

[1] Investment managers are ranked based on performance gross of fees; given the discounted fee structures offered by CalOptima's investment managers, performance on a net-of-fee basis is more compelling relative to peers.

[2] Formal inception date is May 2016.

[3] For peer group standard deviation rankings, a percentile rank of 1 would indicate that the strategy exhibited the lowest standard deviation relative to the peer group, and a percentile rank of 99 would indicate that the strategy exhibited the highest standard deviation relative to the peer group.

Custom Peer Group: Payden Tier One

Gross of Fees Returns as of 6/30/2020[1]	2Q 2020 (%)	1 Year (%)	3 Years (%)	5 Years (%)	10 Years (%)
Tier One: Payden Low Duration	1.43	4.31	3.07	2.24	1.64
Peer Group Median Return	1.63	4.20	2.95	2.30	1.79
Peer Group Rank (percentile)	59	42	36	56	68

Standard Deviation as of 6/30/2020[2]	3 Years (%)	5 Years (%)	10 Years (%)
Tier One: Payden Low Duration	0.94	0.86	0.77
Median Standard Deviation	1.10	1.02	0.89
Peer Group Rank (percentile)	16	13	7

- The Payden Tier One portfolio's trailing returns rank in the second quartile of the peer group over the one- and three-year time periods, and in the third quartile over the trailing quarter as well as five- and ten-year time periods.
- Standard deviation has ranked very favorably versus peers over all trailing periods.

[1] Investment managers are ranked based on performance gross of fees; given the discounted fee structures offered by CalOptima's investment managers, performance on a net-of-fee basis is more compelling relative to peers.

[2] For peer group standard deviation rankings, a percentile rank of 1 would indicate that the strategy exhibited the lowest standard deviation relative to the peer group, and a percentile rank of 99 would indicate that the strategy exhibited the highest standard deviation relative to the peer group.

Custom Peer Group: Wells Capital Tier One

Gross of Fees Returns as of 6/30/2020[1]	2Q 2020 (%)	1 Year (%)	3 Years (%)	Since Inception[2] (%)
Tier One: Wells Capital Reserve Account	1.33	4.24	2.95	2.33
Peer Group Median Return	1.63	4.20	2.95	2.44
Peer Group Rank (percentile)	61	47	49	61

Standard Deviation as of 6/30/2020[3]	3 Years (%)
Tier One: Wells Capital Reserve Account	0.99
Median Standard Deviation	1.10
Peer Group Rank (percentile)	19

- The Wells Capital Tier One portfolio slightly underperformed the peer group over the trailing quarter but slightly outperformed over the one-, three-year and since inception time periods.
- Standard deviation has ranked very favorably versus peers over the trailing three-year period.

[1] Investment managers are ranked based on performance gross of fees; given the discounted fee structures offered by CalOptima's investment managers, performance on a net-of-fee basis is more compelling relative to peers.

[2] Formal inception date is May 2016.

[3] For peer group standard deviation rankings, a percentile rank of 1 would indicate that the strategy exhibited the lowest standard deviation relative to the peer group, and a percentile rank of 99 would indicate that the strategy exhibited the highest standard deviation relative to the peer group.

Custom Peer Group: MetLife Tier Two

Gross of Fees Returns as of 6/30/2020[1]	2Q 2020 (%)	1 Year (%)	3 Years (%)	5 Years (%)
Tier Two: MetLife STAMP 1-5 Year	1.68	5.18	3.24	2.57
Peer Group Median Return	0.72	4.59	3.20	2.31
Peer Group Rank (percentile)	9	1	44	27

Standard Deviation as of 6/30/2020[2]	3 Years (%)	5 Years (%)
Tier Two: MetLife STAMP 1-5 Year	1.23	1.27
Median Standard Deviation	1.41	1.35
Peer Group Rank (percentile)	36	41

- MetLife's Tier Two portfolio outperformed the peer group in the second quarter of 2020 and over the trailing one-, three-, and five-year time periods.
- Standard deviation for the strategy ranks in the second quartile of the peer group over the trailing three- and five-year periods.

[1] Investment managers are ranked based on performance gross of fees; given the discounted fee structures offered by CalOptima's investment managers, performance on a net-of-fee basis is more compelling relative to peers.

[2] For peer group standard deviation rankings, a percentile rank of 1 would indicate that the strategy exhibited the lowest standard deviation relative to the peer group, and a percentile rank of 99 would indicate that the strategy exhibited the highest standard deviation relative to the peer group.

Performance Attribution

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Performance Attribution

- The following pages present attribution data for the MetLife Tier One and Tier Two portfolios, the Payden & Rygel Tier One portfolio, and the Wells Capital Tier One portfolio.
- Attribution represents outperformance or underperformance, based on active investment decisions across fixed income sub-sectors, relative to a manager's benchmark index. Attribution data demonstrates where managers are able to most effectively add incremental value versus the benchmark.
- Attribution data is provided by the investment managers and is presented gross of investment management fees as of September 30, 2020. Attribution data fields will vary slightly across investment managers.

MetLife Tier One Performance Attribution[1]

Gross of Fees as of 9/30/2020

Benchmark Relative Attribution (basis points)	ICE BofA Merrill Lynch 1-3 Year US Treasury		ICE BofA Merrill Lynch 1-3 Year AAA-A US Corp & Govt	
	3Q 2020	1 Year	3Q 2020	1 Year
Duration	7	-11	8	-2
Yield Curve	0	-3	0	-3
Sector Selection	22	53	14	33
Treasury	0	0	0	0
Agency	2	4	-1	-1
Corporate	8	33	3	19
Financial	4	14	1	4
Industrial	4	16	2	13
Utilities	0	3	0	2
MBS	0	0	0	0
CMBS	2	3	2	3
ABS	1	3	1	3
Municipal	9	10	9	9
Total Excess Return[2]	29	39	22	28
MetLife Tier One Return	39	397	39	397
Benchmark Return	10	358	17	368

[1] Performance attribution provided by MetLife.

[2] May not add to actual out/underperformance due to rounding.

Payden & Rygel Tier One Performance Attribution[1]

Gross of Fees as of 9/30/2020

Benchmark Relative Attribution (basis points)	ICE BofA Merrill Lynch 1-3 Year US Treasury		ICE BofA Merrill Lynch 1-3 Year AAA-A US Corp & Govt	
	3Q 2020	1 Year	3Q 2020	1 Year
Duration	0	0	0	2
Yield Curve	0	0	-1	0
Sector Selection	23	37	18	25
Treasury	0	-1	3	5
Agency	1	2	0	0
Corporate	5	18	1	7
Financial	4	10	1	2
Industrial	1	7	0	4
Utilities	0	1	0	1
ABS/MBS	4	8	3	6
Municipal	13	10	11	7
Residual	0	0	0	0
Total Excess Return[2]	23	37	17	27
Payden & Rygel Tier One Return	34	395	34	395
Benchmark Return	10	358	17	368

[1] Performance attribution provided by Payden.

[2] May not add to actual out/underperformance due to rounding.

Wells Capital Tier One Performance Attribution[1]

Gross of Fees as of 9/30/2020

Benchmark Relative Attribution (basis points)	ICE BofA Merrill Lynch 1-3 Year US Treasury		ICE BofA Merrill Lynch 1-3 Year AAA-A US Corp & Govt	
	3Q 2020	1 Year	3Q 2020	1 Year
Duration	-1	-1	3	9
Sector Selection	25	31	14	11
Treasury[2]	NA	NA	NA	NA
Agency	1	1	0	-2
Corporate	9	12	3	-7
Financial	5	9	1	-5
Industrial	4	2	2	1
Utilities	0	0	0	-2
MBS	1	2	0	1
CMBS	0	0	0	0
ABS	4	8	0	4
Municipal	11	6	10	10
Error Factor	0	3	2	3
Total Excess Return[3]	24	30	17	20
Wells Capital Tier One Return (%)	35	388	35	388
Benchmark Return (%)	10	358	17	368

[1] Performance attribution provided by Wells Capital.

[2] Treasury sector selection attribution is included in Duration figure.

[3] May not add to actual out/underperformance due to rounding.

MetLife Tier Two Performance Attribution[1]

Gross of Fees as of 9/30/2020

Benchmark Relative Attribution (basis points)	ICE BofA Merrill Lynch 1-5 Year US Treasury		ICE BofA Merrill Lynch 1-5 Year AAA-A US Corp & Govt	
	3Q 2020	1 Year	3Q 2020	1 Year
Duration	4	-16	6	-4
Yield Curve	0	2	0	1
Sector Selection	42	63	29	39
Treasury	0	0	0	0
Agency	2	4	-2	-2
Corporate	14	41	5	23
Financial	7	19	2	9
Industrial	7	19	3	12
Utilities	0	3	0	2
MBS	0	0	0	0
CMBS	1	2	1	2
ABS	1	2	1	2
Municipal	24	14	24	14
Total Excess Return[2]	46	49	35	36
MetLife Tier Two Return	59	509	59	509
Benchmark Return	13	460	24	473

[1] Performance attribution provided by MetLife.

[2] May not add to actual out/underperformance due to rounding.

Appendices

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Characteristics

Tier One: Payden Low Duration | As of September 30, 2020

Account Information

Account Name	**Tier One: Payden Low Duration**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**7/01/99**
Account Type	**US Fixed Income Short Term**
Benchmark	**ICE BofA 1-3 Yrs US Treasuries TR**
Universe	**eV US Short Duration Fixed Inc Net**

Portfolio Performance Summary

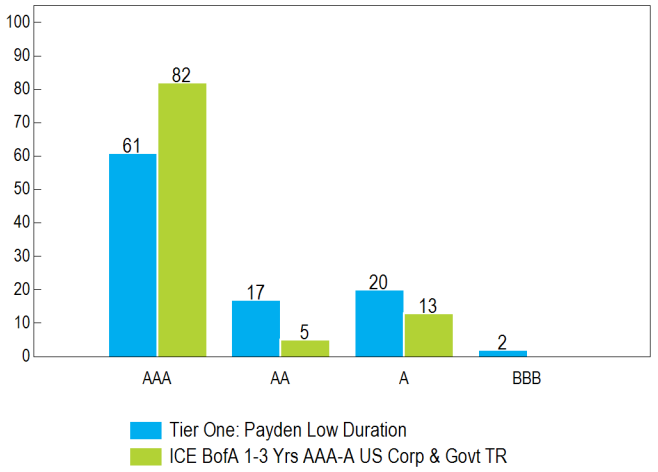
	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Tier One: Payden Low Duration(Gross)	0.344	3.369	3.948	3.062	2.249	1.575	3.052	Jul-99
Tier One: Payden Low Duration(Net)	0.323	3.306	3.864	2.983	2.172	1.473	--	
ICE BofA 1-3 Yrs US Treasuries TR	*0.104*	*3.051*	*3.576*	*2.645*	*1.806*	*1.278*	*2.905*	*Jul-99*
ICE BofA 1-3 Yrs US Corp & Govt TR	*0.274*	*3.110*	*3.735*	*2.877*	*2.116*	*1.605*	*3.227*	*Jul-99*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*0.174*	*3.103*	*3.675*	*2.788*	*1.988*	*1.485*	*3.117*	*Jul-99*

Tier One: Payden Low Duration Fixed Income Characteristics vs. ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR

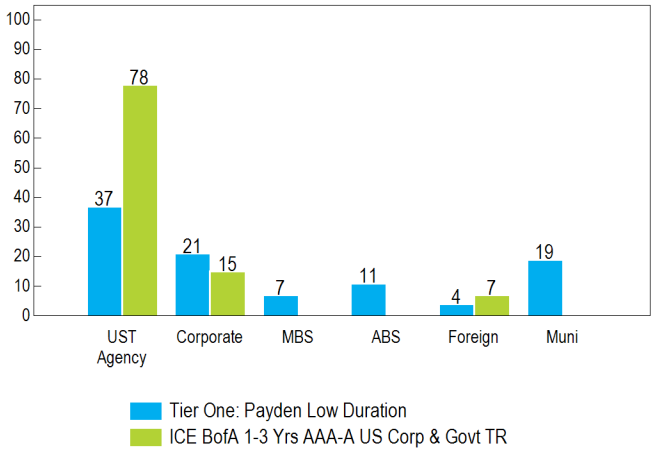
	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.41	0.22	0.55
Average Duration	1.89	1.92	1.89
Average Quality	AA	AAA	AA

Allocation weights may not add to 100% due to rounding.

Credit Quality Allocation



US Sector Allocation



Tier One: Wells Capital Reserve Account | As of September 30, 2020

Account Information

Account Name	**Tier One: Wells Capital Reserve Account**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**5/01/16**
Account Type	**US Fixed Income Short Term**
Benchmark	**ICE BofA 1-3 Yrs US Treasuries TR**
Universe	**eV US Short Duration Fixed Inc Net**

Portfolio Performance Summary

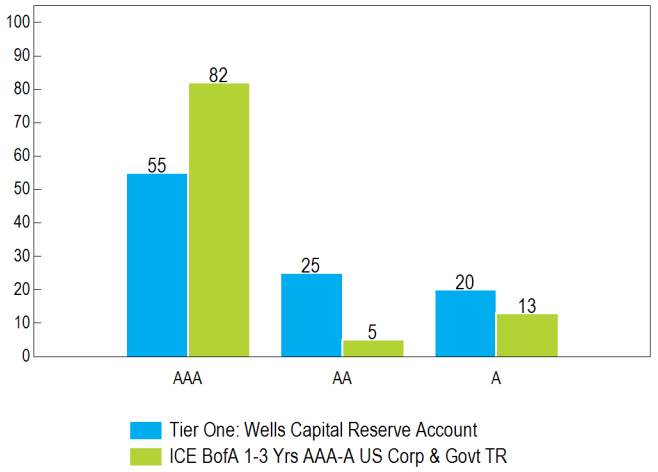
	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Tier One: Wells Capital Reserve Account(Gross)	0.345	3.289	3.880	2.945	--	--	2.277	May-16
Tier One: Wells Capital Reserve Account(Net)	0.327	3.230	3.800	2.867	--	--	2.202	
ICE BofA 1-3 Yrs US Treasuries TR	*0.104*	*3.051*	*3.576*	*2.645*	*1.806*	*1.278*	*1.932*	*May-16*
ICE BofA 1-3 Yrs US Corp & Govt TR	*0.274*	*3.110*	*3.735*	*2.877*	*2.116*	*1.605*	*2.223*	*May-16*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*0.174*	*3.103*	*3.675*	*2.788*	*1.988*	*1.485*	*2.104*	*May-16*

Tier One: Wells Capital Reserve Account Fixed Income Characteristics
vs. ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR

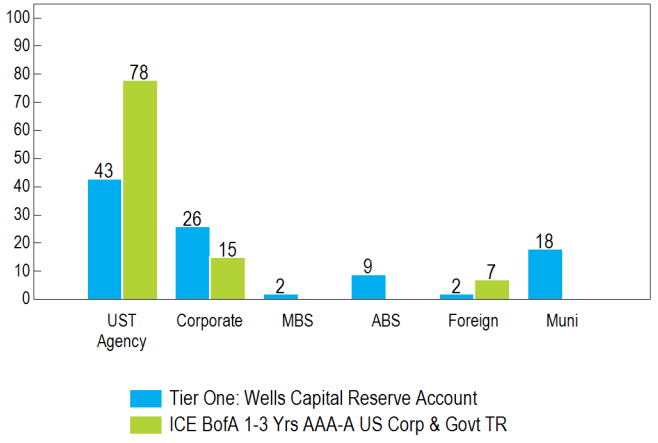
Fixed Income Characteristics	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Yield to Maturity	0.31	0.22	0.48
Average Duration	1.70	1.92	1.67
Average Quality	AA	AAA	AA

Allocation weights may not add to 100% due to rounding.

Credit Quality Allocation



US Sector Allocation



Tier One: MetLife STAMP 1-3 Year | As of September 30, 2020

Account Information

Account Name	**Tier One: MetLife STAMP 1-3 Year**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**5/01/16**
Account Type	**US Fixed Income Short Term**
Benchmark	**ICE BofA 1-3 Yrs US Treasuries TR**
Universe	**eV US Short Duration Fixed Inc Net**

Portfolio Performance Summary

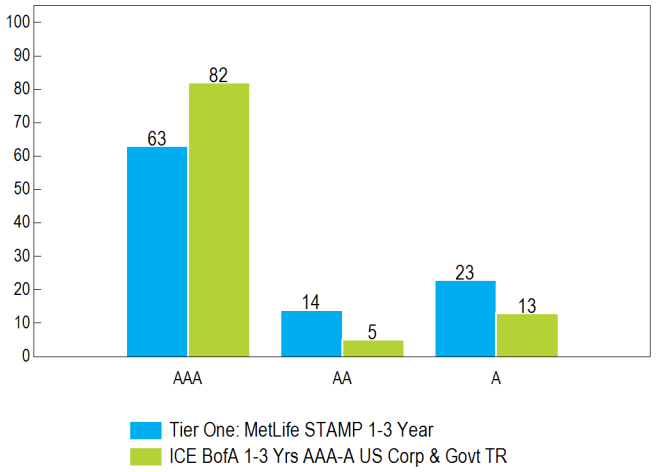
	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Tier One: MetLife STAMP 1-3 Year(Gross)	0.389	3.345	3.966	2.863	--	--	2.227	May-16
Tier One: MetLife STAMP 1-3 Year(Net)	0.368	3.281	3.881	2.785	--	--	2.147	
ICE BofA 1-3 Yrs US Treasuries TR	*0.104*	*3.051*	*3.576*	*2.645*	*1.806*	*1.278*	*1.932*	*May-16*
ICE BofA 1-3 Yrs US Corp & Govt TR	*0.274*	*3.110*	*3.735*	*2.877*	*2.116*	*1.605*	*2.223*	*May-16*
ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR	*0.174*	*3.103*	*3.675*	*2.788*	*1.988*	*1.485*	*2.104*	*May-16*

Tier One: MetLife STAMP 1-3 Year Fixed Income Characteristics vs. ICE BofA 1-3 Yrs AAA-A US Corp & Govt TR

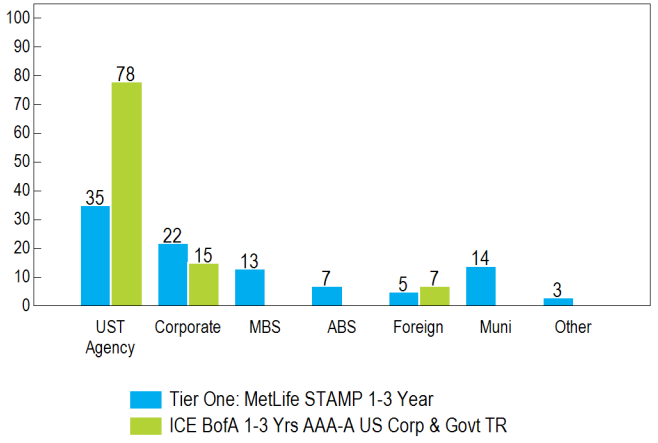
Fixed Income Characteristics	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Yield to Maturity	0.44	0.22	0.52
Average Duration	1.58	1.92	1.59
Average Quality	AA	AAA	AA

Allocation weights may not add to 100% due to rounding.

Credit Quality Allocation



US Sector Allocation



Tier Two: MetLife STAMP 1-5 Year | As of September 30, 2020

Account Information

Account Name	**Tier Two: MetLife STAMP 1-5 Year**
Account Structure	**Separate Account**
Investment Style	**Active**
Inception Date	**4/01/13**
Account Type	**US Fixed Income Short Term**
Benchmark	**ICE BofA 1-5 Yrs US Treasuries TR**
Universe	**eV US Short Duration Fixed Inc Net**

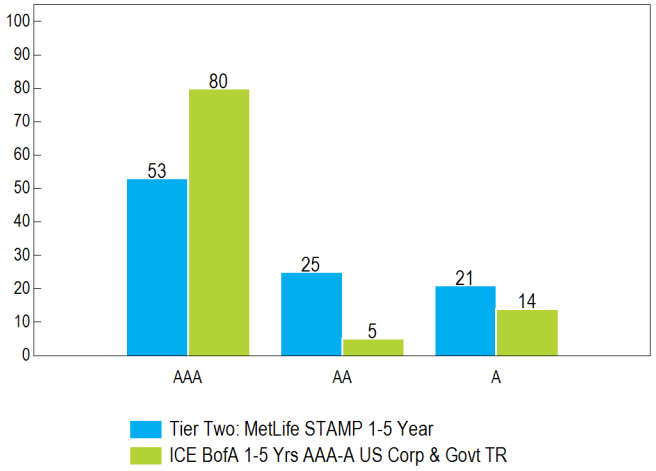
Portfolio Performance Summary

	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	10 Yrs (%)	Inception (%)	Inception Date
Tier Two: MetLife STAMP 1-5 Year(Gross)	0.587	4.542	5.086	3.296	2.521	--	2.119	Apr-13
Tier Two: MetLife STAMP 1-5 Year(Net)	0.555	4.444	4.955	3.167	2.394	--	1.992	
ICE BofA 1-5 Yrs US Treasuries TR	*0.126*	*4.231*	*4.597*	*3.182*	*2.193*	*1.718*	*1.799*	*Apr-13*
ICE BofA 1-5 Yrs US Corp & Govt TR	*0.423*	*4.264*	*4.821*	*3.481*	*2.607*	*2.142*	*2.152*	*Apr-13*
ICE BofA 1-5 Yrs AAA-A US Corp & Govt TR	*0.239*	*4.274*	*4.729*	*3.344*	*2.416*	*1.962*	*1.998*	*Apr-13*

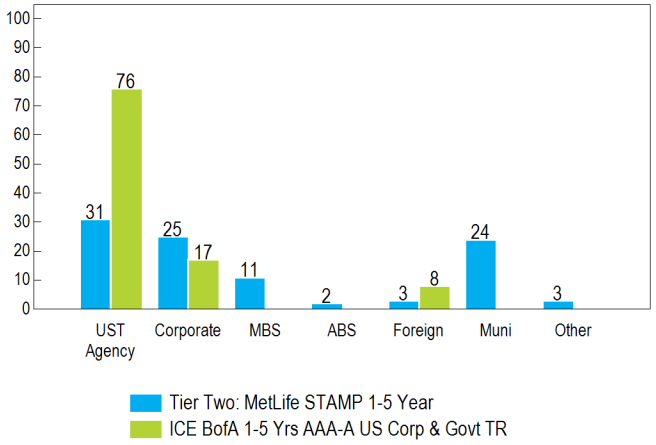
Tier Two: MetLife STAMP 1-5 Year Fixed Income Characteristics vs. ICE BofA 1-5 Yrs AAA-A US Corp & Govt TR

	Portfolio Q3-20	Index Q3-20	Portfolio Q2-20
Fixed Income Characteristics			
Yield to Maturity	0.53	0.28	0.61
Average Duration	2.48	2.70	2.53
Average Quality	AA	AAA	AA

Credit Quality Allocation



US Sector Allocation



Allocation weights may not add to 100% due to rounding.

Holdings

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
Cash							
	CASH OR STIF	USD	(280,247.51)	(280,247.51)	0.00	1.000	(0.17)%
Total for Cash			**(280,247.51)**	**(280,247.51)**	**0.00**		**(0.17)%**
Treasuries							
19,966,000.000	U.S. TREASURY NOTE Mat: 8/31/22 Cpn: 0.13% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 9/11/20 St Date: 9/14/20	91282CAG6	19,962,939.76 1,493.61	19,966,000.00 2,137.25	3,060.24	100.000	12.43%
26,046,000.000	U.S. TREASURY NOTE Mat: 9/15/23 Cpn: 0.13% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 9/15/20 St Date: 9/16/20	91282CAK7	26,022,122.78 1,013.49	26,024,634.21 1,439.01	2,511.42	99.918	16.20%
Total for Treasuries			**45,985,062.54** **2,507.10**	**45,990,634.21** **3,576.26**	**5,571.66**		**28.63%**
Government Related							
910,000.000	INTL FINANCE CORP Mat: 1/25/21 Cpn: 2.25% Moody's: Aaa S&P: AAA Fitch: Tr Date: 1/18/18 St Date: 1/25/18	45950KCM0	907,324.60 0.00	915,884.90 3,753.75	8,560.30	100.647	0.57%
1,350,000.000	INTL BANK RECON & DEVELOP Mat: 7/23/21 Cpn: 2.75% Moody's: Aaa S&P: AAA Fitch: Tr Date: 7/18/18 St Date: 7/25/18	459058GH0	1,346,841.00 0.00	1,377,763.14 7,012.50	30,922.14	102.057	0.86%
1,560,000.000	IBRD C 1/27/21 1X Mat: 1/27/23 Cpn: 1.75% Moody's: Aaa S&P: AAA Fitch: Tr Date: 1/24/20 St Date: 1/28/20	45905U5U4	1,560,000.00 75.83	1,567,755.40 4,853.33	7,755.40	100.497	0.98%
510,000.000	INTER-AMERICAN DEVELOPMENT BANK Mat: 5/24/23 Cpn: 0.50% Moody's: Aaa S&P: AAA Fitch: Tr Date: 4/17/20 St Date: 4/24/20	4581X0DM7	509,826.60 0.00	513,314.94 899.58	3,488.34	100.650	0.32%
960,000.000	INTER-AMERICAN DEVELOPMENT BANK Mat: 11/15/23 Cpn: 0.25% Moody's: Aaa S&P: AAA Fitch: Tr Date: 8/25/20 St Date: 9/2/20	4581X0DP0	958,473.60 0.00	958,528.73 193.33	55.13	99.847	0.60%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
840,000.000	IBRD C 12/14/20 1X	45905U5S9	845,863.20	843,007.83	(2,855.37)	100.358	0.53%
	Mat: 12/12/24 Cpn: 2.00%		5,086.67	5,086.67			
	Moody's: Aaa S&P: AAA Fitch:						
	Tr Date: 3/31/20 St Date: 4/1/20						
Total for Government Related			**6,128,329.00**	**6,176,254.94**	**47,925.94**		**3.86%**
			5,162.50	**21,799.17**			
Agencies							
280,000.000	HOUSING URBAN DEVELOPMENT	911759MU9	280,000.00	285,604.11	5,604.11	102.002	0.18%
	Mat: 8/1/21 Cpn: 2.57%		0.00	1,199.33			
	Moody's: Aaa S&P: AA+u Fitch: AAA						
	Tr Date: 3/20/19 St Date: 3/28/19						
830,000.000	FHLB	3130AF5B9	829,460.50	854,379.96	24,919.46	102.937	0.54%
	Mat: 10/12/21 Cpn: 3.00%		0.00	11,689.17			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 10/11/18 St Date: 10/12/18						
250,000.000	FNMA	3135G0W33	249,130.00	255,934.79	6,804.79	102.374	0.16%
	Mat: 9/6/22 Cpn: 1.38%		0.00	238.72			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 9/5/19 St Date: 9/6/19						
910,000.000	FHLMC C 12/29/20 Q	3134GV4C9	909,818.00	910,414.39	596.39	100.046	0.57%
	Mat: 12/29/22 Cpn: 0.40%		80.89	930.22			
	Moody's: Aaa S&P: AA+u Fitch: AAA						
	Tr Date: 7/6/20 St Date: 7/7/20						
1,620,000.000	FHLMC	3137EAEQ8	1,615,950.00	1,628,481.33	12,531.33	100.524	1.02%
	Mat: 4/20/23 Cpn: 0.38%		0.00	2,716.88			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 4/17/20 St Date: 4/20/20						
1,690,000.000	FNMA	3135G04Q3	1,684,913.10	1,692,332.40	7,419.30	100.138	1.05%
	Mat: 5/22/23 Cpn: 0.25%		0.00	1,513.96			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 5/20/20 St Date: 5/22/20						
1,540,000.000	FHLMC	3137EAES4	1,535,503.20	1,541,237.98	5,734.78	100.080	0.96%
	Mat: 6/26/23 Cpn: 0.25%		0.00	1,015.97			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 6/24/20 St Date: 6/26/20						
1,460,000.000	FNMA	3135G05G4	1,456,861.00	1,461,156.25	4,295.25	100.079	0.91%
	Mat: 7/10/23 Cpn: 0.25%		0.00	821.25			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 7/8/20 St Date: 7/10/20						

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
1,500,000.000	FHLMC	3137EAEV7	1,498,470.00	1,501,027.02	2,557.02	100.069	0.93%
	Mat: 8/24/23 Cpn: 0.25%		0.00	416.67			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 8/19/20 St Date: 8/21/20						
1,090,000.000	FHLMC	3137EAEW5	1,089,640.30	1,090,815.67	1,175.37	100.075	0.68%
	Mat: 9/8/23 Cpn: 0.25%		0.00	204.38			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 9/2/20 St Date: 9/4/20						
435,000.000	FHLB	3130AGWK7	433,977.75	456,241.31	22,263.56	104.883	0.28%
	Mat: 8/15/24 Cpn: 1.50%		0.00	833.75			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 8/15/19 St Date: 8/16/19						
1,430,000.000	FHLMC C 1/21/21 Q	3134GWAR7	1,430,000.00	1,431,636.95	1,636.95	100.115	0.89%
	Mat: 7/21/25 Cpn: 0.75%		0.00	2,085.42			
	Moody's: Aaa S&P: AA+u Fitch: AAA						
	Tr Date: 7/14/20 St Date: 7/21/20						
Total for Agencies			**13,013,723.85**	**13,109,262.14**	**95,538.29**		**8.17%**
			80.89	**23,665.70**			
Taxable Muni							
310,000.000	CA SAN MARCOS REDEV AGY TAB TXB	79876CBQ0	307,904.40	310,012.56	2,108.16	100.004	0.19%
	Mat: 10/1/20 Cpn: 2.00%		0.00	3,100.00			
	Moody's: S&P: AA- Fitch:						
	Tr Date: 12/1/17 St Date: 12/14/17						
500,000.000	CA SAN DIEGO PUBLIC FACS LEASE REV TXB	797299LS1	500,000.00	500,464.10	464.10	100.093	0.32%
	Mat: 10/15/20 Cpn: 2.82%		0.00	6,497.06			
	Moody's: S&P: AA- Fitch: AA-						
	Tr Date: 6/4/18 St Date: 6/21/18						
310,000.000	CA CENTURY HOUSING CORP TXB	156549AA5	310,000.00	310,262.29	262.29	100.085	0.20%
	Mat: 11/1/20 Cpn: 3.82%		0.00	4,939.33			
	Moody's: S&P: AA- Fitch:						
	Tr Date: 2/1/19 St Date: 2/7/19						
350,000.000	CA LOS ANGELES MUNI IMPT CORP LEASE TXB	544587C30	360,734.50	350,825.15	(9,909.35)	100.236	0.22%
	Mat: 11/1/20 Cpn: 3.15%		0.00	4,587.92			
	Moody's: S&P: AA- Fitch: AA-						
	Tr Date: 4/26/17 St Date: 5/1/17						
735,000.000	CA INLAND VLY REDEV AGY TAB TXB	45750TAJ2	750,993.60	744,028.25	(6,965.35)	101.228	0.46%
	Mat: 3/1/21 Cpn: 3.98%		8,363.30	2,435.91			
	Moody's: S&P: AA Fitch:						
	Tr Date: 6/12/18 St Date: 6/14/18						

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
410,000.000	CA ST EDU FACS AUTH REV-CHAPMAN UNV TXB Mat: 4/1/21 Cpn: 2.26% Moody's: A2 S&P: Fitch: Tr Date: 11/9/17 St Date: 11/16/17	130179KQ6	410,000.00 0.00	412,845.53 4,626.85	2,845.53	100.694	0.26%
1,400,000.000	CA STATE GO/ULT TXBL Mat: 4/1/21 Cpn: 2.80% Moody's: Aa2 S&P: AA- Fitch: AA Tr Date: 4/18/18 St Date: 4/25/18	13063DGA0	1,400,056.00 0.00	1,417,353.03 19,600.00	17,297.03	101.240	0.89%
230,064.132	CA DEPT WTR RESOURCES-PWR SUPPLY TXB Mat: 5/1/21 Cpn: 1.71% Moody's: WR S&P: AA+ Fitch: WD Tr Date: 9/22/17 St Date: 9/26/17	13066YTY5	227,747.38 1,587.35	232,035.03 1,642.08	4,287.65	100.857	0.15%
1,100,000.000	CA SAN FRANCISCO AIRPORT COMMN TXB Mat: 5/1/21 Cpn: 2.93% Moody's: A1 S&P: A Fitch: A+ Tr Date: 1/11/19 St Date: 2/7/19	79766DLQ0	1,100,000.00 0.00	1,112,899.35 13,415.42	12,899.35	101.173	0.70%
545,000.000	CA SACRAMENTO TRANSIENT OCC TAX REV TXB Mat: 6/1/21 Cpn: 3.46% Moody's: A1 S&P: Fitch: Tr Date: 10/18/18 St Date: 11/1/18	786073AA4	545,000.00 0.00	550,937.07 6,276.58	5,937.07	101.089	0.35%
450,000.000	CA SAN JOSE REDEV AGY TAB TXB Mat: 8/1/21 Cpn: 2.48% Moody's: S&P: AA Fitch: AA Tr Date: 5/16/18 St Date: 5/18/18	798170AD8	440,883.00 3,317.00	458,270.99 1,860.00	17,387.99	101.838	0.29%
450,000.000	CA HESPERIA REDEV AGY SUCCESSOR TXB Mat: 9/1/21 Cpn: 3.00% Moody's: S&P: AA Fitch: Tr Date: 9/12/18 St Date: 10/2/18	42806KAQ6	446,715.00 0.00	459,024.34 1,125.00	12,309.34	102.005	0.29%
1,025,000.000	CA LA QUINTA REDEV AGY TAB TXB Mat: 9/1/21 Cpn: 4.45% Moody's: S&P: AA Fitch: Tr Date: 4/30/19 St Date: 5/2/19	50420BBD3	1,067,814.25 7,728.78	1,060,171.97 3,801.04	(7,642.28)	103.431	0.66%
520,000.000	CA OAKLAND REDEV AGY PRE-21 TXB Mat: 9/1/21 Cpn: 9.25% Moody's: WR S&P: AA- Fitch: Tr Date: 5/24/18 St Date: 5/29/18	67232PBB8	618,259.20 11,757.78	561,050.93 4,008.33	(57,208.27)	107.894	0.35%
220,000.000	CA BRENTWOOD INFR FIN AUTH REV TXB Mat: 9/2/21 Cpn: 2.81% Moody's: S&P: AA Fitch: Tr Date: 2/7/18 St Date: 2/28/18	10727XVC9	220,000.00 0.00	224,282.22 497.99	4,282.22	101.947	0.14%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
330,000.000	CT STATE GO/ULT TXB Mat: 10/15/21 Cpn: 2.40% Moody's: A1 S&P: A Fitch: A+ Tr Date: 6/13/19 St Date: 6/17/19	20772JKP6	330,594.00 1,364.57	336,540.00 3,653.52	5,946.00	101.982	0.21%
560,000.000	CA SAN DIEGO CITY PUB FACS LEASE TXB Mat: 10/15/21 Cpn: 2.99% Moody's: S&P: AA- Fitch: AA- Tr Date: 6/4/18 St Date: 6/21/18	797299LT9	560,000.00 0.00	575,516.60 7,731.17	15,516.60	102.771	0.36%
540,000.000	HI STATE GO/ULT TXB Mat: 1/1/22 Cpn: 2.77% Moody's: Aa2 S&P: AA+ Fitch: AA+ Tr Date: 2/7/19 St Date: 2/21/19	419792YL4	540,000.00 0.00	556,810.19 3,739.50	16,810.19	103.113	0.35%
640,000.000	CA POMONA REDEV AGY TAX ALLOCATION TXB Mat: 2/1/22 Cpn: 3.55% Moody's: S&P: A+ Fitch: Tr Date: 9/27/18 St Date: 10/11/18	73209MAD9	640,000.00 0.00	663,614.69 3,788.80	23,614.69	103.690	0.42%
655,000.000	CA STATE GO/ULT-TXBL BABS Mat: 3/1/22 Cpn: 6.65% Moody's: Aa2 S&P: AA- Fitch: AA Tr Date: 7/16/19 St Date: 7/18/19	13063BFS6	715,364.80 16,576.05	693,247.43 3,629.79	(22,117.37)	105.839	0.43%
930,000.000	CA SAN FRANCISCO AIRPORT COMMN TXB Mat: 5/1/22 Cpn: 3.05% Moody's: A1 S&P: A Fitch: A+ Tr Date: 1/11/19 St Date: 2/7/19	79766DLR8	930,000.00 0.00	960,305.68 11,803.25	30,305.68	103.259	0.61%
820,000.000	CA UNIV OF CALIFORNIA REV TXB Mat: 5/15/22 Cpn: 3.28% Moody's: Aa3 S&P: AA- Fitch: AA- Tr Date: 12/13/18 St Date: 12/17/18	91412HDJ9	822,878.20 2,392.94	857,584.17 10,170.00	34,705.97	104.583	0.54%
1,500,000.000	CA HEALTH FACS-NO PLACE LIKE HOME-TXB Mat: 6/1/22 Cpn: 1.89% Moody's: Aa3 S&P: AA- Fitch: AA- Tr Date: 11/20/19 St Date: 11/25/19	13032UUZ9	1,500,000.00 0.00	1,531,445.51 9,465.00	31,445.51	102.096	0.96%
340,000.000	CT STATE OF CONNECTICUT GO/ULT TXB Mat: 7/1/22 Cpn: 2.50% Moody's: A1 S&P: A Fitch: A+ Tr Date: 5/29/20 St Date: 6/11/20	20772KJU4	345,718.80 0.00	351,651.86 2,597.22	5,933.06	103.427	0.22%
790,000.000	OR STATE GO/ULT TXB Mat: 8/1/22 Cpn: 0.46% Moody's: Aa1 S&P: AA+ Fitch: AA+ Tr Date: 7/9/20 St Date: 7/16/20	68609TZP6	790,000.00 0.00	793,347.34 748.85	3,347.34	100.424	0.49%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
960,000.000	CA UPPER SANTA CLARA VLY JPA REV TXB Mat: 8/1/22 Cpn: 0.53% Moody's: S&P: AA Fitch: AA- Tr Date: 7/16/20 St Date: 7/23/20	916544ER6	960,000.00 0.00	962,349.24 952.00	2,349.24	100.245	0.60%
350,000.000	CA SAN DIEGO REDEV AGY TAB TXB Mat: 9/1/22 Cpn: 3.25% Moody's: S&P: AA Fitch: Tr Date: 4/20/20 St Date: 4/22/20	79730WAY6	364,962.50 1,611.46	369,128.93 947.92	4,166.43	105.465	0.23%
500,000.000	CA MANTECA REDEV AGY TAB TXB Mat: 10/1/22 Cpn: 1.64% Moody's: S&P: AA Fitch: Tr Date: 2/20/20 St Date: 2/28/20	56453RAW4	500,000.00 0.00	508,915.18 4,851.67	8,915.18	101.783	0.32%
435,000.000	CA PALM DESERT REDEV AGY TAB TXB Mat: 10/1/22 Cpn: 2.75% Moody's: S&P: AA Fitch: Tr Date: 7/23/19 St Date: 7/25/19	696624AV7	442,577.70 3,788.13	447,767.41 5,981.25	5,189.71	102.935	0.28%
810,000.000	CA SACRAMENTO CNTY SANTN DIST REV TXB Mat: 12/1/22 Cpn: 0.63% Moody's: Aa2 S&P: AA Fitch: AA- Tr Date: 6/18/20 St Date: 7/14/20	786134WD4	810,000.00 0.00	816,603.62 1,089.74	6,603.62	100.815	0.51%
500,000.000	TX SAN ANTONIO GO/LTD TXB Mat: 2/1/23 Cpn: 0.48% Moody's: Aaa S&P: AAA Fitch: AA+ Tr Date: 7/1/20 St Date: 7/16/20	79623PEN1	500,000.00 0.00	501,756.33 497.92	1,756.33	100.351	0.31%
500,000.000	CA RIVERSIDE CNTY PENSN OBLG TXB Mat: 2/15/23 Cpn: 2.36% Moody's: A2 S&P: AA Fitch: Tr Date: 4/23/20 St Date: 5/6/20	76913CAX7	500,000.00 0.00	515,805.21 1,509.69	15,805.21	103.161	0.32%
1,470,000.000	CA BAY AREA TOLL AUTH TOLL BRDG REV TXB Mat: 4/1/23 Cpn: 2.18% Moody's: Aa3 S&P: AA Fitch: AA Tr Date: 9/20/19 St Date: 9/26/19	072024WN8	1,470,000.00 0.00	1,534,190.25 16,052.40	64,190.25	104.367	0.96%
320,000.000	CA BAY AREA TOLL AUTH TOLL BRDG REV TXB Mat: 4/1/23 Cpn: 2.23% Moody's: A1 S&P: AA- Fitch: AA- Tr Date: 9/20/19 St Date: 9/26/19	072024WX6	320,000.00 0.00	327,045.39 3,574.40	7,045.39	102.202	0.21%
570,000.000	CT STATE OF CONNECTICUT TXB Mat: 4/15/23 Cpn: 2.92% Moody's: A1 S&P: A Fitch: A+ Tr Date: 3/29/19 St Date: 4/11/19	20772KGM5	570,000.00 0.00	603,289.11 7,677.36	33,289.11	105.840	0.38%

Portfolio Positions

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Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
370,000.000	CA ALAMEDA CNTY JT PWR AUTH LEASE TXB Mat: 6/1/23 Cpn: 3.10% Moody's: Aa1 S&P: AA+ Fitch: AA+ Tr Date: 2/13/20 St Date: 2/18/20	010831DQ5	386,298.50 2,449.35	394,682.38 3,817.17	8,383.88	106.671	0.25%
1,060,000.000	CA SOUTHERN CA PUBLIC POWER TXB Mat: 7/1/23 Cpn: 0.53% Moody's: S&P: AA- Fitch: AA- Tr Date: 9/11/20 St Date: 9/24/20	842475P58	1,060,000.00 0.00	1,061,144.90 108.62	1,144.90	100.108	0.66%
1,110,000.000	CA LOS ALTOS SCH DIST GO BANS TXB Mat: 8/1/23 Cpn: 2.14% Moody's: MIG1 S&P: SP-1+ Fitch: Tr Date: 9/27/19 St Date: 10/17/19	544290JC4	1,110,000.00 0.00	1,111,444.24 3,964.55	1,444.24	100.130	0.69%
300,000.000	MA STATE WATER RES AUTH-GREEN TXB Mat: 8/1/23 Cpn: 1.77% Moody's: Aa1 S&P: AA+ Fitch: AA+ Tr Date: 10/10/19 St Date: 11/1/19	576051VW3	300,000.00 0.00	309,636.43 886.00	9,636.43	103.212	0.19%
1,410,000.000	CA SAN BERNARDINO CCD TXB Mat: 8/1/23 Cpn: 1.96% Moody's: Aa1 S&P: AA Fitch: Tr Date: 11/21/19 St Date: 12/12/19	796720MF4	1,425,026.40 3,358.44	1,466,613.53 4,615.40	41,587.13	104.015	0.92%
450,000.000	CA SAN BERNARDINO CCD TXB Mat: 8/1/23 Cpn: 0.73% Moody's: Aa1 S&P: AA Fitch: Tr Date: 6/17/20 St Date: 7/7/20	796720NP1	450,000.00 0.00	452,480.13 546.75	2,480.13	100.551	0.28%
240,000.000	CA SAN DIEGO PUBLIC FACS WTR REV TXB Mat: 8/1/23 Cpn: 1.33% Moody's: Aa2 S&P: Fitch: AA Tr Date: 4/30/20 St Date: 5/11/20	79730CJG0	240,000.00 0.00	245,601.95 530.80	5,601.95	102.334	0.15%
350,000.000	CA GLENDALE USD GO/ULT TXB Mat: 9/1/23 Cpn: 1.18% Moody's: Aa1 S&P: Fitch: Tr Date: 5/13/20 St Date: 6/2/20	378460YC7	350,000.00 0.00	356,052.45 344.75	6,052.45	101.729	0.22%
500,000.000	CA MOUNTAIN VIEW-WHISMAN SD TXB Mat: 9/1/23 Cpn: 1.16% Moody's: Aaa S&P: AA+ Fitch: Tr Date: 5/1/20 St Date: 5/19/20	62451FKG4	500,000.00 0.00	511,250.69 2,134.00	11,250.69	102.250	0.32%
430,000.000	CA STATE UNIVERSITY TXB Mat: 11/1/23 Cpn: 0.48% Moody's: Aa2 S&P: AA- Fitch: Tr Date: 8/27/20 St Date: 9/17/20	13077DMJ8	430,000.00 0.00	429,739.85 79.43	(260.15)	99.940	0.27%

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Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
550,000.000	CA LOS ANGELES MUNI IMPT CORP LEASE TXB Mat: 11/1/23 Cpn: 0.65% Moody's: S&P: AA- Fitch: Tr Date: 8/14/20 St Date: 8/20/20	544587Y36	550,000.00 0.00	551,872.75 407.15	1,872.75	100.341	0.34%
790,000.000	CA UNIVERSITY OF CALIFORNIA TXB Mat: 5/15/24 Cpn: 0.83% Moody's: Aa2 S&P: AA Fitch: AA Tr Date: 7/10/20 St Date: 7/16/20	91412HFL2	790,000.00 0.00	794,895.31 1,370.98	4,895.31	100.620	0.50%
750,000.000	CA BEVERLY HILLS PFA LEASE REV TXB Mat: 6/1/24 Cpn: 0.73% Moody's: S&P: AA+ Fitch: Tr Date: 9/23/20 St Date: 10/15/20	088006JY8	750,000.00 0.00	750,731.28 0.00	731.28	100.098	0.47%
450,000.000	CA FRESNO USD GO/ULT TXB Mat: 8/1/24 Cpn: 0.72% Moody's: Aa3 S&P: Fitch: Tr Date: 9/17/20 St Date: 9/30/20	3582326S0	450,000.00 0.00	450,443.30 8.99	443.30	100.099	0.28%
Total for Taxable Muni			**31,109,528.23** **64,295.15**	**31,497,966.09** **197,689.57**	**388,437.86**		**19.73%**
Credit							
505,000.000	GOLDMAN SACHS Mat: 12/27/20 Cpn: 2.60% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 3/22/17 St Date: 3/27/17	38141GWG5	504,651.55 0.00	507,721.95 3,428.39	3,070.40	100.539	0.32%
410,000.000	MANUFACTURERS & TRADERS TRUST Mat: 1/25/21 Cpn: 2.63% Moody's: A3 S&P: A Fitch: A Tr Date: 1/22/18 St Date: 1/25/18	55279HAR1	409,446.50 0.00	412,236.55 1,973.13	2,790.05	100.546	0.26%
725,000.000	US BANK CINCINNATI FRN Mat: 4/26/21 Cpn: 0.56% Moody's: A1 S&P: AA- Fitch: AA- Tr Date: 4/24/18 St Date: 4/26/18	90331HNQ2	725,000.00 0.00	725,909.88 750.31	909.88	100.126	0.45%
85,000.000	BNY MELLON Mat: 5/3/21 Cpn: 2.05% Moody's: A1 S&P: A Fitch: AA- Tr Date: 7/30/19 St Date: 8/1/19	06406FAB9	84,758.60 425.94	85,779.88 716.36	1,021.28	100.918	0.05%
300,000.000	PACCAR FINANCIAL FRN Mat: 5/10/21 Cpn: 0.50% Moody's: A1 S&P: A+ Fitch: Tr Date: 5/7/18 St Date: 5/10/18	69371RP34	300,000.00 0.00	300,378.60 218.08	378.60	100.126	0.19%

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Currency: USD

Units	Security			Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
1,030,000.000	CITIZENS BANK			17401QAE1	1,032,575.00	1,042,190.05	9,615.05	101.184	0.65%
	Mat: 5/13/21	Cpn: 2.55%			5,544.83	10,068.25			
	Moody's: Baa1	S&P: A-	Fitch: BBB+						
	Tr Date: 7/25/19	St Date: 7/29/19							
500,000.000	AMERICAN EXPRESS FRN			025816BV0	500,000.00	501,273.50	1,273.50	100.255	0.31%
	Mat: 5/17/21	Cpn: 0.81%			0.00	503.21			
	Moody's: A3	S&P: BBB+	Fitch: A						
	Tr Date: 5/14/18	St Date: 5/17/18							
180,000.000	CITIGROUP			172967KV2	179,911.80	183,056.40	3,144.60	101.698	0.11%
	Mat: 8/2/21	Cpn: 2.35%			2,079.75	693.25			
	Moody's: A3	S&P: BBB+	Fitch: A						
	Tr Date: 7/25/19	St Date: 7/29/19							
775,000.000	NEXTERA ENERGY CAPITAL			65339KAS9	779,960.00	789,845.13	9,885.13	101.916	0.49%
	Mat: 9/1/21	Cpn: 2.40%			1,138.09	1,551.94			
	Moody's: Baa1	S&P: BBB+	Fitch: A-						
	Tr Date: 8/28/19	St Date: 8/30/19							
490,000.000	JOHN DEERE CAPITAL CORP			24422EUK3	489,848.10	503,401.50	13,553.40	102.735	0.31%
	Mat: 9/10/21	Cpn: 3.13%			0.00	893.23			
	Moody's: A2	S&P: A	Fitch: A						
	Tr Date: 9/5/18	St Date: 9/10/18							
325,000.000	HONEYWELL INTL			438516BM7	322,686.35	330,315.38	7,629.03	101.636	0.21%
	Mat: 11/1/21	Cpn: 1.85%			1,503.13	2,505.21			
	Moody's: A2	S&P: A	Fitch: A						
	Tr Date: 7/30/19	St Date: 8/1/19							
800,000.000	MORGAN STANLEY			61746BED4	803,872.00	820,172.00	16,300.00	102.522	0.52%
	Mat: 11/17/21	Cpn: 2.63%			3,850.00	7,816.67			
	Moody's: A2	S&P: BBB+	Fitch: A						
	Tr Date: 7/19/19	St Date: 7/23/19							
126,000.000	MORGAN STANLEY FRN			61746BEE2	127,401.12	126,370.69	(1,030.43)	100.294	0.08%
	Mat: 1/20/22	Cpn: 1.45%			363.56	370.92			
	Moody's: A2	S&P: BBB+	Fitch: A						
	Tr Date: 3/3/17	St Date: 3/8/17							
740,000.000	NATL RURAL UTILITIES			63743HET5	739,348.80	753,878.70	14,529.90	101.876	0.47%
	Mat: 1/21/22	Cpn: 1.75%			0.00	2,733.89			
	Moody's: A2	S&P: A	Fitch: A						
	Tr Date: 1/22/20	St Date: 2/5/20							
300,000.000	US BANK CINCINNATI			90331HPJ6	299,895.00	305,515.50	5,620.50	101.839	0.19%
	Mat: 1/21/22	Cpn: 1.80%			0.00	1,050.00			
	Moody's: A1	S&P: AA-	Fitch: AA-						
	Tr Date: 1/16/20	St Date: 1/21/20							

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Currency: USD

Units	Security			Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
680,000.000	BANK OF AMERICA			06051GGY9	680,000.00	684,855.20	4,855.20	100.714	0.43%
	Mat: 1/23/22	Cpn: 2.74%			0.00	3,516.81			
	Moody's: A2	S&P: A-	Fitch: A+						
	Tr Date: 1/18/18	St Date: 1/23/18							
650,000.000	PACIFICORP			695114CP1	660,484.50	668,021.25	7,536.75	102.773	0.42%
	Mat: 2/1/22	Cpn: 2.95%			9,534.24	3,195.83			
	Moody's: A1	S&P: A+	Fitch: WD						
	Tr Date: 7/26/19	St Date: 7/30/19							
121,000.000	WELLS FARGO FRN			949746SP7	121,000.00	121,286.10	286.10	100.236	0.08%
	Mat: 2/11/22	Cpn: 1.18%			0.00	202.70			
	Moody's: A2	S&P: BBB+	Fitch: A+						
	Tr Date: 2/6/17	St Date: 2/13/17							
650,000.000	WELLS FARGO			94974BFC9	668,089.50	678,447.25	10,357.75	104.377	0.42%
	Mat: 3/8/22	Cpn: 3.50%			9,036.81	1,453.47			
	Moody's: A2	S&P: BBB+	Fitch: A+						
	Tr Date: 7/29/19	St Date: 7/31/19							
660,000.000	AMERIPRISE FINANCIAL			03076CAJ5	658,320.30	684,938.10	26,617.80	103.779	0.43%
	Mat: 3/22/22	Cpn: 3.00%			0.00	495.00			
	Moody's: A3	S&P: A	Fitch:						
	Tr Date: 3/12/19	St Date: 3/22/19							
510,000.000	CITIGROUP FRN			172967LH2	510,000.00	515,066.99	5,066.99	100.994	0.32%
	Mat: 4/25/22	Cpn: 1.20%			0.00	1,126.21			
	Moody's: A3	S&P: BBB+	Fitch: A						
	Tr Date: 4/18/17	St Date: 4/25/17							
500,000.000	NATL RURAL UTILITIES			637432NM3	503,355.00	514,857.50	11,502.50	102.972	0.32%
	Mat: 4/25/22	Cpn: 2.40%			3,200.00	5,200.00			
	Moody's: A1	S&P: A	Fitch: A+						
	Tr Date: 7/30/19	St Date: 8/1/19							
460,000.000	BANK OF AMERICA			06051GHH5	460,000.00	468,687.10	8,687.10	101.889	0.30%
	Mat: 5/17/22	Cpn: 3.50%			0.00	5,991.07			
	Moody's: A2	S&P: A-	Fitch: A+						
	Tr Date: 5/14/18	St Date: 5/17/18							
785,000.000	TRUIST BANK			86787EBE6	784,599.65	814,994.85	30,395.20	103.821	0.51%
	Mat: 5/17/22	Cpn: 2.80%			0.00	8,181.44			
	Moody's: A2	S&P: A	Fitch: A+						
	Tr Date: 5/14/19	St Date: 5/17/19							
620,000.000	AMERICAN EXPRESS			025816CD9	619,256.00	641,600.80	22,344.80	103.484	0.40%
	Mat: 5/20/22	Cpn: 2.75%			0.00	6,204.31			
	Moody's: A3	S&P: BBB+	Fitch: A						
	Tr Date: 5/15/19	St Date: 5/20/19							

Portfolio Positions

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Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
375,000.000	CITIBANK	17325FAY4	377,793.75	380,649.38	2,855.63	101.507	0.24%
	Mat: 5/20/22 Cpn: 2.84%		2,044.13	3,880.88			
	Moody's: Aa3 S&P: A+ Fitch: A+						
	Tr Date: 7/29/19 St Date: 7/31/19						
580,000.000	JOHN DEERE CAPITAL CORP	24422EVA4	579,251.80	596,230.14	16,978.34	102.798	0.37%
	Mat: 6/13/22 Cpn: 1.95%		0.00	3,393.00			
	Moody's: A2 S&P: A Fitch: A						
	Tr Date: 9/9/19 St Date: 9/12/19						
775,000.000	FIFTH THIRD BANK	316773CU2	783,021.25	801,693.33	18,672.08	103.444	0.50%
	Mat: 6/15/22 Cpn: 2.60%		55.97	5,933.06			
	Moody's: Baa1 S&P: BBB+ Fitch: A-						
	Tr Date: 12/12/19 St Date: 12/16/19						
920,000.000	PNC BANK	69353RFP8	920,000.00	933,202.00	13,202.00	101.435	0.58%
	Mat: 7/22/22 Cpn: 2.23%		0.00	3,935.76			
	Moody's: A2 S&P: A Fitch: A+						
	Tr Date: 7/18/19 St Date: 7/23/19						
550,000.000	PACCAR FINANCIAL	69371RN77	550,335.50	569,758.75	19,423.25	103.593	0.36%
	Mat: 8/10/22 Cpn: 2.30%		5,481.67	1,792.08			
	Moody's: A1 S&P: A+ Fitch:						
	Tr Date: 7/12/19 St Date: 7/16/19						
290,000.000	BNY MELLON	06406RAK3	289,907.20	299,079.90	9,172.70	103.131	0.19%
	Mat: 8/23/22 Cpn: 1.95%		0.00	596.92			
	Moody's: A1 S&P: A Fitch: AA-						
	Tr Date: 8/20/19 St Date: 8/23/19						
545,000.000	CATERPILLAR FINANCIAL	14913Q3A5	544,242.45	560,894.93	16,652.48	102.917	0.35%
	Mat: 9/6/22 Cpn: 1.90%		0.00	719.10			
	Moody's: A3 S&P: A Fitch: A						
	Tr Date: 9/3/19 St Date: 9/6/19						
430,000.000	KEYBANK	49327M2T0	433,091.70	446,271.20	13,179.50	103.784	0.28%
	Mat: 9/14/22 Cpn: 2.30%		4,258.19	467.03			
	Moody's: A3 S&P: A- Fitch: A-						
	Tr Date: 8/15/19 St Date: 8/19/19						
285,000.000	PACCAR FINANCIAL	69371RQ33	284,652.30	294,054.45	9,402.15	103.177	0.18%
	Mat: 9/26/22 Cpn: 2.00%		0.00	79.17			
	Moody's: A1 S&P: A+ Fitch:						
	Tr Date: 9/23/19 St Date: 9/26/19						
730,000.000	GOLDMAN SACHS FRN	38148YAB4	729,284.60	733,239.74	3,955.14	100.444	0.46%
	Mat: 10/31/22 Cpn: 1.04%		700.83	1,308.30			
	Moody's: A3 S&P: BBB+ Fitch: A						
	Tr Date: 11/14/17 St Date: 11/16/17						

Portfolio Positions

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Currency: USD

Units	Security			Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
475,000.000	CITIGROUP			17308CC46	475,000.00	483,865.88	8,865.88	101.867	0.30%
	Mat: 11/4/22	Cpn: 2.31%			0.00	4,484.32			
	Moody's: A3	S&P: BBB+	Fitch: A						
	Tr Date: 10/28/19	St Date: 11/4/19							
655,000.000	PNC BANK			69353RFS2	655,000.00	667,320.55	12,320.55	101.881	0.42%
	Mat: 12/9/22	Cpn: 2.03%			0.00	4,132.61			
	Moody's: A2	S&P: A	Fitch: A+						
	Tr Date: 12/4/19	St Date: 12/9/19							
800,000.000	WAL-MART STORES			931142DU4	827,264.00	835,252.00	7,988.00	104.407	0.52%
	Mat: 12/15/22	Cpn: 2.35%			4,438.89	5,535.56			
	Moody's: Aa2	S&P: AA	Fitch: AA						
	Tr Date: 3/6/20	St Date: 3/10/20							
800,000.000	PRECISION CASTPARTS			740189AG0	806,160.00	835,012.00	28,852.00	104.377	0.52%
	Mat: 1/15/23	Cpn: 2.50%			888.89	4,222.22			
	Moody's: A2	S&P: AA-	Fitch:						
	Tr Date: 7/30/19	St Date: 8/1/19							
865,000.000	BNY MELLON			06406RAM9	864,394.50	893,519.05	29,124.55	103.297	0.56%
	Mat: 1/27/23	Cpn: 1.85%			0.00	2,844.89			
	Moody's: A1	S&P: A	Fitch: AA-						
	Tr Date: 1/21/20	St Date: 1/28/20							
570,000.000	FIFTH THIRD BANK			31677QBS7	569,521.20	586,239.30	16,718.10	102.849	0.37%
	Mat: 1/30/23	Cpn: 1.80%			0.00	1,738.50			
	Moody's: A3	S&P: A-	Fitch: A-						
	Tr Date: 1/28/20	St Date: 1/31/20							
430,000.000	ADOBE			00724PAA7	429,410.90	443,572.95	14,162.05	103.157	0.28%
	Mat: 2/1/23	Cpn: 1.70%			0.00	1,218.33			
	Moody's: A2	S&P: A	Fitch:						
	Tr Date: 1/22/20	St Date: 2/3/20							
610,000.000	HUNTINGTON NATL BANK			44644MAA9	609,487.60	626,765.85	17,278.25	102.749	0.39%
	Mat: 2/3/23	Cpn: 1.80%			0.00	1,769.00			
	Moody's: A3	S&P: A-	Fitch: A-						
	Tr Date: 1/28/20	St Date: 2/4/20							
435,000.000	PNC BANK			69353RFT0	435,000.00	443,088.83	8,088.83	101.860	0.28%
	Mat: 2/24/23	Cpn: 1.74%			0.00	779.27			
	Moody's: A2	S&P: A	Fitch: A+						
	Tr Date: 2/20/20	St Date: 2/25/20							
790,000.000	TRUIST BANK			89788JAB5	789,447.00	804,279.25	14,832.25	101.808	0.50%
	Mat: 3/9/23	Cpn: 1.25%			0.00	603.47			
	Moody's: A2	S&P: A	Fitch: A+						
	Tr Date: 3/4/20	St Date: 3/9/20							

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Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
985,000.000	DUKE ENERGY CAROLINAS	26442CAQ7	995,766.05	1,032,373.58	36,607.53	104.810	0.64%
	Mat: 3/15/23 Cpn: 2.50%		9,302.78	1,094.44			
	Moody's: Aa2 S&P: A Fitch: WD						
	Tr Date: 7/29/19 St Date: 7/31/19						
775,000.000	TRUIST FIN CORP	05531FBJ1	774,426.50	805,628.00	31,201.50	103.952	0.50%
	Mat: 3/16/23 Cpn: 2.20%		0.00	710.42			
	Moody's: A3 S&P: A- Fitch: A						
	Tr Date: 9/9/19 St Date: 9/16/19						
375,000.000	JPMORGAN CHASE	46647PBB1	375,000.00	389,718.75	14,718.75	103.925	0.25%
	Mat: 4/1/23 Cpn: 3.21%		0.00	6,013.13			
	Moody's: A2 S&P: A- Fitch: AA-						
	Tr Date: 3/15/19 St Date: 3/22/19						
200,000.000	JOHN DEERE CAPITAL CORP	24422EVE6	199,952.00	204,019.00	4,067.00	102.010	0.13%
	Mat: 4/6/23 Cpn: 1.20%		0.00	1,346.67			
	Moody's: A2 S&P: A Fitch: A						
	Tr Date: 3/4/20 St Date: 3/9/20						
800,000.000	EXXON MOBIL	30231GBL5	800,000.00	823,496.00	23,496.00	102.937	0.52%
	Mat: 4/15/23 Cpn: 1.57%		0.00	5,795.24			
	Moody's: Aa1 S&P: AA Fitch:						
	Tr Date: 4/13/20 St Date: 4/15/20						
490,000.000	PEPSICO	713448EY0	489,029.80	495,527.20	6,497.40	101.128	0.31%
	Mat: 5/1/23 Cpn: 0.75%		0.00	1,531.25			
	Moody's: A1 S&P: A+ Fitch: WD						
	Tr Date: 4/29/20 St Date: 5/1/20						
560,000.000	APPLE	037833DV9	558,476.80	566,076.00	7,599.20	101.085	0.35%
	Mat: 5/11/23 Cpn: 0.75%		0.00	1,633.33			
	Moody's: Aa1 S&P: AA+ Fitch:						
	Tr Date: 5/4/20 St Date: 5/11/20						
175,000.000	CHEVRON	166764BV1	175,000.00	178,443.13	3,443.13	101.968	0.11%
	Mat: 5/11/23 Cpn: 1.14%		0.00	776.51			
	Moody's: Aa2 S&P: AA Fitch:						
	Tr Date: 5/7/20 St Date: 5/11/20						
150,000.000	INTERCONTINENTALEXCHANGE	45866FAM6	149,854.50	150,522.00	667.50	100.348	0.09%
	Mat: 6/15/23 Cpn: 0.70%		0.00	119.58			
	Moody's: A3 S&P: BBB+ Fitch:						
	Tr Date: 8/17/20 St Date: 8/20/20						
600,000.000	CATERPILLAR	14913R2D8	599,664.00	603,057.00	3,393.00	100.510	0.38%
	Mat: 7/7/23 Cpn: 0.65%		0.00	899.17			
	Moody's: A3 S&P: A Fitch: A						
	Tr Date: 7/6/20 St Date: 7/8/20						

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security			Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
780,000.000	COMERICA			200340AS6	826,807.80	845,949.78	19,141.98	108.455	0.53%
	Mat: 7/31/23	Cpn: 3.70%			1,683.50	4,890.17			
	Moody's: A3	S&P: BBB+	Fitch: A-						
	Tr Date: 2/19/20	St Date: 2/21/20							
670,000.000	GILEAD SCIENCES			375558BW2	670,135.50	671,594.60	1,459.10	100.238	0.42%
	Mat: 9/29/23	Cpn: 0.75%			0.00	13.96			
	Moody's: A3	S&P: A	Fitch:						
	Tr Date: 9/23/20	St Date: 9/30/20							
250,000.000	FIRST REPUBLIC BANK			33616CHQ6	250,000.00	256,963.75	6,963.75	102.786	0.16%
	Mat: 2/12/24	Cpn: 1.91%			0.00	650.61			
	Moody's: Baa1	S&P: A-	Fitch: A-						
	Tr Date: 2/5/20	St Date: 2/12/20							
450,000.000	JPMORGAN CHASE			46647PBS4	450,000.00	450,123.75	123.75	100.028	0.28%
	Mat: 9/16/24	Cpn: 0.65%			0.00	122.44			
	Moody's: A2	S&P: A-	Fitch: AA-						
	Tr Date: 9/9/20	St Date: 9/16/20							
50,000.000	NIKE			654106AH6	49,932.00	53,791.75	3,859.75	107.584	0.03%
	Mat: 3/27/25	Cpn: 2.40%			0.00	13.33			
	Moody's: A1	S&P: AA-	Fitch:						
	Tr Date: 3/25/20	St Date: 3/27/20							
170,000.000	ORACLE			68389XBT1	169,937.10	182,297.80	12,360.70	107.234	0.11%
	Mat: 4/1/25	Cpn: 2.50%			0.00	2,125.00			
	Moody's: A3	S&P: A	Fitch: A-						
	Tr Date: 3/30/20	St Date: 4/1/20							
Total for Credit					**32,450,707.57**	**33,124,372.37**	**673,664.80**		**20.71%**
					65,531.21	**148,008.37**			
Mortgage-Backed									
143,435.920	FNA 2011-M5 A2 CMBS			3136A07H4	142,629.09	145,804.33	3,175.24	101.651	0.09%
	Mat: 7/25/21	Cpn: 2.94%			316.28	351.42			
	Moody's: Aaa	S&P: AA+u	Fitch: AAA						
	Tr Date: 9/26/18	St Date: 9/28/18							
276,275.148	FNA 2018-M5 A2 CMBS			3136B1XP4	281,770.54	278,845.34	(2,925.20)	100.930	0.17%
	Mat: 9/25/21	Cpn: 3.56%			792.30	819.62			
	Moody's: Aaa	S&P: AA+u	Fitch: AAA						
	Tr Date: 4/10/18	St Date: 4/30/18							
1,200,000.000	FHMS K020 A2 CMBS			3137ATRW4	1,220,943.75	1,232,736.00	11,792.25	102.728	0.77%
	Mat: 5/25/22	Cpn: 2.37%			1,467.31	2,373.00			
	Moody's: Aaa	S&P: AA+u	Fitch: AAA						
	Tr Date: 7/25/19	St Date: 7/30/19							

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
493,113.885	FNA 2013-M1 A2 CMBS Mat: 8/25/22 Cpn: 2.36% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 10/28/19 St Date: 10/31/19	3136ABPW7	496,427.00 971.70	504,702.55 971.69	8,275.56	102.350	0.31%
1,540,000.000	FHMS KSMC A2 CMBS Mat: 1/25/23 Cpn: 2.62% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 2/24/20 St Date: 2/27/20	3137B04Y7	1,580,425.00 2,908.46	1,619,790.48 3,355.92	39,365.48	105.181	1.01%
613,286.779	FHMS KS01 A2 CMBS Mat: 1/25/23 Cpn: 2.52% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 11/22/19 St Date: 11/27/19	3137B1U75	620,617.48 1,117.06	633,237.00 1,288.92	12,619.52	103.253	0.39%
1,370,000.000	FHMS K029 A2 CMBS Mat: 2/25/23 Cpn: 3.32% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 8/14/19 St Date: 8/19/19	3137B36J2	1,431,430.08 2,245.61	1,454,675.59 3,790.33	23,245.51	106.181	0.91%
413,168.578	FHMS K724 A1 CMBS Mat: 3/25/23 Cpn: 2.78% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 7/9/18 St Date: 7/12/18	3137BTTZ4	410,392.60 350.46	422,107.48 955.80	11,714.88	102.164	0.26%
1,380,000.000	FHMS K031 A2 Mat: 4/25/23 Cpn: 3.30% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 3/5/20 St Date: 3/10/20	3137B3NX2	1,470,239.06 1,138.50	1,475,207.58 3,795.00	4,968.52	106.899	0.92%
53,820.103	FHMS J22F A1 CMBS Mat: 5/25/23 Cpn: 3.45% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 11/7/18 St Date: 11/19/18	3137FJYA1	53,818.65 92.95	54,180.91 154.91	362.26	100.670	0.03%
1,410,000.000	FHMS K033 A2 Mat: 7/25/23 Cpn: 3.06% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 2/27/20 St Date: 3/3/20	3137B4WB8	1,479,839.06 239.70	1,501,833.30 3,595.50	21,994.24	106.513	0.94%
820,000.000	FHMS K034 A2 Mat: 7/25/23 Cpn: 3.53% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 3/6/20 St Date: 3/11/20	3137B5JM6	881,500.00 804.28	884,365.08 2,412.85	2,865.08	107.849	0.55%
654,939.551	FHMS KI05 A Mat: 7/25/24 Cpn: 0.49% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 1/16/20 St Date: 1/28/20	3137FQXG3	654,939.55 0.00	657,540.32 53.28	2,600.77	100.397	0.41%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
627,063.270	FHMS KJ30 A1 CMBS	3137FUZN7	627,051.36	628,526.84	1,475.48	100.233	0.39%
	Mat: 1/25/25 Cpn: 0.53%		265.71	274.86			
	Moody's: Aaa S&P: AA+u Fitch: AAA						
	Tr Date: 7/23/20 St Date: 7/30/20						
762,998.345	FHMS KJ28 A1	3137FREB3	762,995.29	788,826.60	25,831.31	103.385	0.49%
	Mat: 2/25/25 Cpn: 1.77%		973.17	1,122.88			
	Moody's: Aaa S&P: AA+u Fitch: AAA						
	Tr Date: 2/19/20 St Date: 2/27/20						
Total for Mortgage-Backed			**12,115,018.51**	**12,282,379.40**	**167,360.89**		**7.66%**
			13,683.47	**25,315.99**			
Asset-Backed							
132,444.918	BMW 2018-1 A3 LEASE	05586CAC8	132,426.51	133,072.44	645.93	100.474	0.08%
	Mat: 7/20/21 Cpn: 3.26%		0.00	131.93			
	Moody's: Aaa S&P: AAA Fitch:						
	Tr Date: 10/10/18 St Date: 10/17/18						
86,196.077	HONDA 2017-3 A3 CAR	43814PAC4	86,186.74	86,342.09	155.35	100.169	0.05%
	Mat: 9/20/21 Cpn: 1.79%		0.00	55.72			
	Moody's: S&P: AAA Fitch: AAA						
	Tr Date: 9/25/17 St Date: 9/29/17						
12,009.027	JOHN DEERE 2017-B A3 EQP	47788BAD6	12,008.15	12,015.86	7.71	100.057	0.01%
	Mat: 10/15/21 Cpn: 1.82%		0.00	9.71			
	Moody's: Aaa S&P: Fitch: AAA						
	Tr Date: 7/11/17 St Date: 7/18/17						
270,000.000	BMW 2018-1 A4 LEASE	05586CAD6	269,997.60	272,767.50	2,769.90	101.025	0.17%
	Mat: 3/21/22 Cpn: 3.36%		0.00	277.20			
	Moody's: Aaa S&P: AAA Fitch:						
	Tr Date: 10/10/18 St Date: 10/17/18						
628,376.994	HONDA 2018-3 A3 CAR	43815HAC1	628,290.78	636,722.47	8,431.69	101.328	0.40%
	Mat: 8/22/22 Cpn: 2.95%		0.00	514.92			
	Moody's: Aaa S&P: Fitch: AAA						
	Tr Date: 8/21/18 St Date: 8/28/18						
340,000.000	VOLKSWAGEN 2019-A A3 LEASE	92867XAD8	339,994.63	346,743.56	6,748.93	101.983	0.22%
	Mat: 11/21/22 Cpn: 1.99%		0.00	206.74			
	Moody's: S&P: AAA Fitch: AAA						
	Tr Date: 10/1/19 St Date: 10/4/19						
400,000.000	MERCEDES 2020-A A3 CAR LEASE	58770FAC6	399,947.28	406,610.00	6,662.72	101.653	0.25%
	Mat: 12/15/22 Cpn: 1.84%		0.00	327.11			
	Moody's: Aaa S&P: AAA Fitch:						
	Tr Date: 1/21/20 St Date: 1/29/20						

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
755,000.000	JOHN DEERE 2019-A A3 EQP Mat: 7/17/23 Cpn: 2.91% Moody's: Aaa S&P: Fitch: AAA Tr Date: 3/5/19 St Date: 3/13/19	47789JAD8	754,907.21 0.00	772,179.27 976.47	17,272.06	102.275	0.48%
970,000.000	TOYOTA 2019-A A3 CAR Mat: 7/17/23 Cpn: 2.91% Moody's: Aaa S&P: AAA Fitch: Tr Date: 2/5/19 St Date: 2/13/19	89239AAD5	969,823.27 0.00	991,778.44 1,254.53	21,955.17	102.245	0.62%
720,000.000	HONDA 2019-3 A3 CAR Mat: 8/15/23 Cpn: 1.78% Moody's: Aaa S&P: AAA Fitch: Tr Date: 8/20/19 St Date: 8/27/19	43815NAC8	719,994.02 0.00	734,015.52 569.60	14,021.50	101.947	0.46%
730,000.000	TOYOTA 2019-C A3 CAR Mat: 9/15/23 Cpn: 1.91% Moody's: Aaa S&P: AAA Fitch: Tr Date: 8/6/19 St Date: 8/14/19	89238UAD2	729,994.01 0.00	744,005.78 619.69	14,011.77	101.919	0.46%
1,640,000.000	MERCEDES 2020-B A3 LEASE Mat: 11/15/23 Cpn: 0.40% Moody's: S&P: (P)AAA Fitch: AAA Tr Date: 9/15/20 St Date: 9/23/20	58769EAC2	1,639,916.85 0.00	1,639,916.85 145.78	0.00	99.995	1.02%
550,000.000	FIFTH THIRD 2019-1 A3 CAR Mat: 12/15/23 Cpn: 2.64% Moody's: Aaa S&P: AAA Fitch: Tr Date: 4/30/19 St Date: 5/8/19	31680YAD9	549,879.11 0.00	562,651.65 645.33	12,772.54	102.300	0.35%
950,000.000	BMW 2019-A A3 CAR Mat: 1/25/24 Cpn: 1.92% Moody's: S&P: AAA Fitch: AAA Tr Date: 9/10/19 St Date: 9/18/19	05588CAC6	949,872.32 0.00	967,462.90 304.00	17,590.58	101.838	0.60%
1,710,000.000	HARLEY 2019-A A3 CYCLE Mat: 2/15/24 Cpn: 2.34% Moody's: Aaa S&P: Fitch: AAA Tr Date: 6/19/19 St Date: 6/26/19	41284WAC4	1,709,867.65 0.00	1,742,356.62 1,778.40	32,488.97	101.892	1.09%
790,000.000	MERCEDES 2019-1 A3 CAR Mat: 3/15/24 Cpn: 1.94% Moody's: Aaa S&P: AAA Fitch: Tr Date: 9/18/19 St Date: 9/25/19	58769TAD7	789,891.22 0.00	807,647.02 681.16	17,755.80	102.234	0.50%
340,000.000	SDART 2020-2 A3 CAR Mat: 4/15/24 Cpn: 0.67% Moody's: Aaa S&P: Fitch: AAA Tr Date: 7/14/20 St Date: 7/22/20	80285RAD0	339,960.87 0.00	341,118.94 101.24	1,158.07	100.329	0.21%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
850,000.000	VERIZON 2019-C A1A PHONE Mat: 4/22/24 Cpn: 1.94% Moody's: S&P: AAA Fitch: AAA Tr Date: 10/1/19 St Date: 10/8/19	92348AAA3	849,934.47 0.00	870,564.90 503.86	20,630.43	102.419	0.54%
250,000.000	DRIVE 2020-2 A3 CAR Mat: 5/15/24 Cpn: 0.83% Moody's: Aaa S&P: AAA Fitch: Tr Date: 6/10/20 St Date: 6/17/20	26208VAD8	249,990.45 0.00	251,218.50 92.22	1,228.05	100.487	0.16%
960,000.000	SDART 2020-3 A3 CAR Mat: 7/15/24 Cpn: 0.52% Moody's: Aaa S&P: Fitch: AAA Tr Date: 9/15/20 St Date: 9/23/20	80285WAD9	959,908.22 0.00	962,308.80 110.93	2,400.58	100.241	0.60%
1,230,000.000	JOHN DEERE 2020-A A3 EQP Mat: 8/15/24 Cpn: 1.10% Moody's: Aaa S&P: Fitch: AAA Tr Date: 3/4/20 St Date: 3/11/20	47789KAC7	1,229,924.85 0.00	1,247,207.70 601.33	17,282.85	101.399	0.78%
830,000.000	TOYOTA 2020-C A3 CAR Mat: 10/15/24 Cpn: 0.44% Moody's: Aaa S&P: AAA Fitch: Tr Date: 7/21/20 St Date: 7/27/20	89237VAB5	829,936.09 0.00	832,247.64 162.31	2,311.55	100.271	0.52%
1,200,000.000	HONDA 2020-3 A3 CAR Mat: 10/18/24 Cpn: 0.37% Moody's: S&P: AAA Fitch: AAA Tr Date: 9/22/20 St Date: 9/29/20	43813KAC6	1,199,823.72 0.00	1,200,824.40 24.67	1,000.68	100.069	0.75%
350,000.000	BMW 2020-A A3 CAR Mat: 10/25/24 Cpn: 0.48% Moody's: S&P: AAA Fitch: AAA Tr Date: 7/8/20 St Date: 7/15/20	09661RAD3	349,973.58 0.00	351,059.45 28.00	1,085.87	100.303	0.22%
830,000.000	CAPITAL ONE 2020-1 A3 CAR Mat: 11/15/24 Cpn: 1.60% Moody's: S&P: AAA Fitch: AAA Tr Date: 2/11/20 St Date: 2/19/20	14043MAC5	829,823.54 0.00	848,896.61 590.22	19,073.07	102.277	0.53%
570,000.000	MERCEDES 2020-1 A3 CAR Mat: 2/18/25 Cpn: 0.55% Moody's: S&P: AAA Fitch: AAA Tr Date: 6/16/20 St Date: 6/23/20	58769VAC4	569,955.48 0.00	572,700.66 139.33	2,745.18	100.474	0.36%
Total for Asset-Backed			**18,092,228.62** **0.00**	**18,334,435.58** **10,852.41**	**242,206.96**		**11.42%**
Grand Total			**158,614,350.82** **151,260.32**	**160,235,057.22** **430,907.47**	**1,620,706.40**		**100.00%**

MetLife Investment Management

Source Account Name	Security ID	Security Description 1	Security Description 2	Sector	Shares/Par	Base Cost	Accrued Interest	Base Market Value	Base Unrealized Gain	Base Unrealized Loss	Percent of Asset	Moody's Rating	S&P Rating	Fitch Rating
CALOPTIMA S1-3	GL-110000	CASH			0.0000	4,124,518.10	0.00	4,124,518.10	0.00	0.00	0.00			
CALOPTIMA S1-3	GL-220010	PAYABLE FOR INVESTMENTS PURCHASED			0.0000	-4,001,427.07	0.00	-4,001,427.07	0.00	0.00	0.00			
CALOPTIMA S1-3	02582JJH4	AMERICAN EXPRESS CREDIT AC 8 A	3.180% 04/15/2024 DD 09/24/18	Asset Backed	389,000.0000	396,550.23	549.78	399,919.85	3,369.62	0.00	0.25	NR	AAA	AAA
CALOPTIMA S1-3	02582JJH4	AMERICAN EXPRESS CREDIT AC 8 A	3.180% 04/15/2024 DD 09/24/18	Asset Backed	243,000.0000	247,739.54	343.44	249,821.40	2,081.86	0.00	0.16	NR	AAA	AAA
CALOPTIMA S1-3	02582JJH4	AMERICAN EXPRESS CREDIT AC 8 A	3.180% 04/15/2024 DD 09/24/18	Asset Backed	614,000.0000	625,936.47	867.79	631,235.96	5,299.49	0.00	0.40	NR	AAA	AAA
CALOPTIMA S1-3	05522RCZ9	BA CREDIT CARD TRUST A2 A2	3.000% 09/15/2023 DD 05/17/18	Asset Backed	1,200,000.0000	1,214,370.97	1,600.00	1,217,904.72	3,533.75	0.00	0.77	Aaa	AAA	NR
CALOPTIMA S1-3	05522RCZ9	BA CREDIT CARD TRUST A2 A2	3.000% 09/15/2023 DD 05/17/18	Asset Backed	430,000.0000	435,149.04	573.33	436,415.86	1,266.82	0.00	0.27	Aaa	AAA	NR
CALOPTIMA S1-3	05586VAD4	BMW VEHICLE LEASE TRUST 2 1 A4	2.920% 08/22/2022 DD 03/20/19	Asset Backed	1,900,000.0000	1,917,791.78	1,695.22	1,930,452.63	12,660.85	0.00	1.22	Aaa	AAA	NR
CALOPTIMA S1-3	17305EFM2	CITIBANK CREDIT CARD ISS A1 A1	2.880% 01/23/2023 DD 01/24/14	Asset Backed	855,000.0000	854,142.23	4,788.00	861,940.55	7,798.32	0.00	0.54	Aaa	NR	AAA
CALOPTIMA S1-3	17305EGK5	CITIBANK CREDIT CARD ISS A1 A1	2.490% 01/20/2023 DD 01/31/18	Asset Backed	365,000.0000	366,525.49	1,792.45	367,490.54	965.05	0.00	0.23	Aaa	NR	AAA
CALOPTIMA S1-3	26208RAD7	DRIVE AUTO RECEIVABLES TR 2 A3	3.040% 03/15/2023 DD 03/20/19	Asset Backed	106,401.6300	106,395.21	143.76	106,625.75	230.54	0.00	0.07	Aaa	AAA	NR
CALOPTIMA S1-3	26209AAE1	DRIVE AUTO RECEIVABLES TRU 4 B	2.230% 01/16/2024 DD 09/18/19	Asset Backed	585,000.0000	584,939.27	579.80	593,187.43	8,248.16	0.00	0.37	Aa1	AA	NR
CALOPTIMA S1-3	31680YAB3	FIFTH THIRD AUTO TRUST 2 1 A2A	2.660% 05/16/2022 DD 05/08/19	Asset Backed	217,669.5500	217,662.92	257.33	218,323.45	660.53	0.00	0.14	Aaa	AAA	NR
CALOPTIMA S1-3	34528QHK3	FORD CREDIT FLOORPLAN MAS 1 A1	0.700% 09/15/2025 DD 09/18/20	Asset Backed	1,570,000.0000	1,569,908.96	396.86	1,574,120.31	4,211.35	0.00	0.99	Aaa	NR	AAA
CALOPTIMA S1-3	362569AE5	GM FINANCIAL AUTOMOBILE LE 3 B	0.760% 10/21/2024 DD 09/29/20	Asset Backed	2,000,000.0000	2,000,703.13	126.67	1,999,373.40	0.00	-1,329.73	1.26	Aa1	AA+	NR
CALOPTIMA S1-3	47788BAD6	JOHN DEERE OWNER TRUST 20 B A3	1.820% 10/15/2021 DD 07/18/17	Asset Backed	18,585.3800	18,496.40	15.03	18,595.57	99.17	0.00	0.01	Aaa	NR	AAA
CALOPTIMA S1-3	47789JAB2	JOHN DEERE OWNER TRUST 20 A A2	2.850% 12/15/2021 DD 03/13/19	Asset Backed	171,057.3000	171,053.85	216.67	171,387.37	333.52	0.00	0.11	Aaa	NR	AAA
CALOPTIMA S1-3	65478LAB5	NISSAN AUTO LEASE TRUST B A2A	2.270% 10/15/2021 DD 07/24/19	Asset Backed	293,533.5600	293,521.30	296.14	294,465.15	943.85	0.00	0.19	Aaa	AAA	AAA
CALOPTIMA S1-3	3137BJP56	FHLMC MULTICLASS MTG K046 A1	2.697% 01/25/2025 DD 06/01/15	CMBS	275,607.3270	286,932.61	619.43	286,926.05	0.00	-6.56	0.18	Agency	AA+	AAA
CALOPTIMA S1-3	3137BKRH5	FHLMC MULTICLASS MTG K047 A1	2.827% 12/25/2024 DD 07/01/15	CMBS	320,513.3270	326,378.12	755.08	335,395.98	9,017.86	0.00	0.21	Agency	AA+	AAA
CALOPTIMA S1-3	3137BWVV3	FHLMC MULTICLASS MTG KJ13 A2	2.864% 08/25/2022 DD 04/01/17	CMBS	147,584.0900	149,419.87	352.23	152,242.42	2,822.55	0.00	0.10	Agency	AA+	Agency
CALOPTIMA S1-3	3137FHPZ0	FHLMC MULTICLASS MTG KC02 A1	3.254% 02/25/2025 DD 09/01/18	CMBS	548,119.4150	582,044.24	1,486.32	584,791.73	2,747.49	0.00	0.37	Agency	AA+	Agency
CALOPTIMA S1-3	31381QB54	FNMA POOL #0467260	4.410% 03/01/2021 DD 03/01/11	CMBS	1,040,659.7920	1,044,691.21	3,824.42	1,040,184.09	0.00	-4,507.12	0.66	Agency	AA+	Agency
CALOPTIMA S1-3	31381R5T7	FNMA POOL #0468958	3.770% 09/01/2021 DD 09/01/11	CMBS	1,805,000.0000	1,817,057.30	5,670.71	1,846,220.69	29,163.39	0.00	1.16	Agency	AA+	Agency
CALOPTIMA S1-3	3138EKXL4	FNMA POOL #0AL3382	VAR RT 03/01/2023 DD 03/01/13	CMBS	292,815.2550	295,082.95	567.33	301,265.47	6,182.52	0.00	0.19	Agency	AA+	Agency
CALOPTIMA S1-3	3138L0MH1	FNMA POOL #0AM0359	2.310% 08/01/2022 DD 08/01/12	CMBS	1,027,496.1770	1,034,067.65	1,977.93	1,052,054.99	17,987.34	0.00	0.66	Agency	AA+	Agency
CALOPTIMA S1-3	3138L2GH4	FNMA POOL #0AM1999	1.870% 07/01/2021 DD 01/01/13	CMBS	971,232.2550	963,194.51	1,513.50	980,762.71	17,568.20	0.00	0.62	Agency	AA+	Agency
CALOPTIMA S1-3	3138L2GH4	FNMA POOL #0AM1999	1.870% 07/01/2021 DD 01/01/13	CMBS	248,063.6480	247,534.73	386.57	250,497.83	2,963.10	0.00	0.16	Agency	AA+	Agency
CALOPTIMA S1-3	3138NJAE8	FNMA POOL #0FN0004	VAR RT 12/01/2020 DD 03/01/11	CMBS	68,677.2740	68,796.53	210.55	68,657.80	0.00	-138.73	0.04	Agency	AA+	Agency
CALOPTIMA S1-3	3140JAU97	FNMA POOL #0BM6007	VAR RT 05/01/2023 DD 05/01/19	CMBS	595,256.1960	616,133.15	1,291.71	614,196.49	0.00	-1,936.66	0.39	Agency	AA+	Agency
CALOPTIMA S1-3	025816BM0	AMERICAN EXPRESS CO	2.500% 08/01/2022 DD 08/01/17	Corporates	1,100,000.0000	1,121,683.23	4,583.33	1,139,918.90	18,235.67	0.00	0.72	A3	BBB+	A
CALOPTIMA S1-3	0258M0EH8	AMERICAN EXPRESS CREDIT CORP	VAR RT 03/03/2022 DD 03/03/17	Corporates	1,000,000.0000	1,001,399.28	742.16	1,006,495.99	5,096.71	0.00	0.63	A2	A-	A
CALOPTIMA S1-3	05531FBG7	TRUIST FINANCIAL CORP	3.050% 06/20/2022 DD 03/18/19	Corporates	750,000.0000	772,225.46	6,417.71	781,623.08	9,397.62	0.00	0.49	A3	A-	A
CALOPTIMA S1-3	05531FBJ1	TRUIST FINANCIAL CORP	2.200% 03/16/2023 DD 09/16/19	Corporates	1,175,000.0000	1,174,382.26	1,077.08	1,222,417.74	48,035.48	0.00	0.77	A3	A-	A
CALOPTIMA S1-3	06051GGS2	BANK OF AMERICA CORP	VAR RT 10/01/2021 DD 09/18/17	Corporates	970,000.0000	970,000.00	11,290.80	970,000.00	0.00	0.00	0.61	A2	A-	A+
CALOPTIMA S1-3	06051GGS2	BANK OF AMERICA CORP	VAR RT 10/01/2021 DD 09/18/17	Corporates	800,000.0000	800,001.34	9,312.00	800,000.00	0.00	-1.34	0.50	A2	A-	A+
CALOPTIMA S1-3	14913Q2H1	CATERPILLAR FINANCIAL SERVICES	VAR RT 03/15/2021 DD 03/15/18	Corporates	1,065,000.0000	1,018,142.58	229.24	1,065,766.80	47,624.22	0.00	0.67	A3	A	A
CALOPTIMA S1-3	14913R2D8	CATERPILLAR FINANCIAL SERVICES	0.650% 07/07/2023 DD 07/08/20	Corporates	1,190,000.0000	1,189,384.60	1,783.35	1,195,667.89	6,283.29	0.00	0.75	A3	A	A
CALOPTIMA S1-3	172967LC3	CITIGROUP INC	2.900% 12/08/2021 DD 12/08/16	Corporates	1,355,000.0000	1,359,757.32	12,334.26	1,391,921.16	32,163.84	0.00	0.88	A3	BBB+	A
CALOPTIMA S1-3	17308CC46	CITIGROUP INC	VAR RT 11/04/2022 DD 11/04/19	Corporates	1,260,000.0000	1,260,000.00	11,895.24	1,283,077.57	23,077.57	0.00	0.81	A3	BBB+	A
CALOPTIMA S1-3	17401QAN1	CITIZENS BANK NA/PROVIDENCE RI	2.250% 10/30/2020 DD 11/01/17	Corporates	900,000.0000	899,231.91	8,493.75	900,384.83	1,152.92	0.00	0.57	Baa1	A-	BBB+
CALOPTIMA S1-3	17401QAN1	CITIZENS BANK NA/PROVIDENCE RI	2.250% 10/30/2020 DD 11/01/17	Corporates	250,000.0000	249,753.86	2,359.38	250,106.90	353.04	0.00	0.16	Baa1	A-	BBB+
CALOPTIMA S1-3	38141GGQ1	GOLDMAN SACHS GROUP INC/THE	5.250% 07/27/2021 DD 07/27/11	Corporates	525,000.0000	536,494.85	4,900.00	546,027.15	9,532.30	0.00	0.34	A3	BBB+	A
CALOPTIMA S1-3	38141GGQ1	GOLDMAN SACHS GROUP INC/THE	5.250% 07/27/2021 DD 07/27/11	Corporates	525,000.0000	532,987.26	4,900.00	546,027.14	13,039.88	0.00	0.34	A3	BBB+	A
CALOPTIMA S1-3	438516CC8	HONEYWELL INTERNATIONAL INC	0.483% 08/19/2022 DD 08/19/20	Corporates	1,565,000.0000	1,565,000.00	881.88	1,567,575.24	2,575.24	0.00	0.99	A2	A	A
CALOPTIMA S1-3	4581X0CN6	INTER-AMERICAN DEVELOPMENT BAN	1.750% 04/14/2022 DD 04/15/15	Corporates	755,000.0000	756,231.15	6,129.13	772,523.92	16,292.77	0.00	0.49	Aaa	AAA	AAA
CALOPTIMA S1-3	4581X0CN6	INTER-AMERICAN DEVELOPMENT BAN	1.750% 04/14/2022 DD 04/15/15	Corporates	460,000.0000	460,731.80	3,734.31	470,676.83	9,945.03	0.00	0.30	Aaa	AAA	AAA
CALOPTIMA S1-3	4581X0CN6	INTER-AMERICAN DEVELOPMENT BAN	1.750% 04/14/2022 DD 04/15/15	Corporates	315,000.0000	315,496.80	2,557.19	322,311.30	6,814.50	0.00	0.20	Aaa	AAA	AAA
CALOPTIMA S1-3	4581X0CZ9	INTER-AMERICAN DEVELOPMENT BAN	1.750% 09/14/2022 DD 09/14/17	Corporates	750,000.0000	745,912.07	619.79	772,211.62	26,299.55	0.00	0.49	Aaa	AAA	AAA
CALOPTIMA S1-3	4581X0CZ9	INTER-AMERICAN DEVELOPMENT BAN	1.750% 09/14/2022 DD 09/14/17	Corporates	3,000,000.0000	2,997,251.06	2,479.17	3,088,846.47	91,595.41	0.00	1.95	Aaa	AAA	AAA
CALOPTIMA S1-3	459058DT7	INTERNATIONAL BANK FOR RECONST	2.250% 06/24/2021 DD 06/25/14	Corporates	1,525,000.0000	1,530,897.60	9,245.31	1,547,783.50	16,885.90	0.00	0.98	Aaa	AAA	AAA
CALOPTIMA S1-3	459058GX5	INTERNATIONAL BANK FOR RECONST	1.875% 06/19/2023 DD 06/19/19	Corporates	1,100,000.0000	1,112,226.78	5,843.75	1,147,993.00	35,766.22	0.00	0.72	Aaa	AAA	NR
CALOPTIMA S1-3	459200KD2	INTERNATIONAL BUSINESS MACHINE	VAR RT 05/13/2021 DD 05/15/19	Corporates	868,000.0000	867,547.94	772.07	870,148.30	2,600.36	0.00	0.55	A2	A	NR
CALOPTIMA S1-3	49327M2Q6	KEYBANK NA/CLEVELAND OH	2.500% 11/22/2021 DD 11/22/16	Corporates	500,000.0000	496,188.10	4,479.17	512,266.20	16,078.10	0.00	0.32	A3	A-	A-
CALOPTIMA S1-3	49327M2Y9	KEYBANK NA/CLEVELAND OH	VAR RT 02/01/2022 DD 02/01/19	Corporates	1,670,000.0000	1,670,000.00	2,577.88	1,680,348.09	10,348.09	0.00	1.06	A3	A-	A-
CALOPTIMA S1-3	61746BEB8	MORGAN STANLEY	VAR RT 04/21/2021 DD 04/21/16	Corporates	1,297,000.0000	1,303,450.32	4,365.74	1,306,044.80	2,594.48	0.00	0.82	A3	BBB+	A
CALOPTIMA S1-3	61746BED4	MORGAN STANLEY	2.625% 11/17/2021 DD 11/17/16	Corporates	1,085,000.0000	1,075,721.27	10,601.35	1,112,103.30	36,382.03	0.00	0.70	A3	BBB+	A
CALOPTIMA S1-3	65339KBF6	NEXTERA ENERGY CAPITAL HOLDING	2.900% 04/01/2022 DD 04/04/19	Corporates	1,500,000.0000	1,540,464.27	21,750.00	1,553,174.81	12,710.54	0.00	0.98	Baa1	BBB+	A-
CALOPTIMA S1-3	69353RFT0	PNC BANK NA	VAR RT 02/24/2023 DD 02/25/20	Corporates	250,000.0000	250,000.00	447.85	254,516.33	4,516.33	0.00	0.16	A2	A	A+
CALOPTIMA S1-3	69371RP26	PACCAR FINANCIAL CORP	3.100% 05/10/2021 DD 05/10/18	Corporates	1,515,000.0000	1,514,913.77	18,394.63	1,541,330.18	26,416.41	0.00	0.97	A1	A+	NR
CALOPTIMA S1-3	69371RP34	PACCAR FINANCIAL CORP	VAR RT 05/10/2021 DD 05/10/18	Corporates	1,500,000.0000	1,500,575.13	1,098.89	1,501,802.34	1,227.21	0.00	0.95	A1	A+	NA
CALOPTIMA S1-3	74432QBP9	PRUDENTIAL FINANCIAL INC	4.500% 11/15/2020 DD 11/18/10	Corporates	835,000.0000	836,337.48	14,195.00	839,206.11	2,868.63	0.00	0.53	A3	A	A-
CALOPTIMA S1-3	74456QBP0	PUBLIC SERVICE ELECTRIC AND GA	1.900% 03/15/2021 DD 03/03/16	Corporates	735,000.0000	728,881.19	620.67	739,648.48	10,767.29	0.00	0.47	Aa3	A	NR
CALOPTIMA S1-3	87236YAG3	TD AMERITRADE HOLDING CORP	VAR RT 11/01/2021 DD 11/01/18	Corporates	1,875,000.0000	1,859,214.43	2,163.59	1,881,393.56	22,179.13	0.00	1.19	A2	A	NR
CALOPTIMA S1-3	92343VBR4	VERIZON COMMUNICATIONS INC	5.150% 09/15/2023 DD 09/18/13	Corporates	1200000	1,344,865.88	2,746.67	1,359,855.40	14,989.52	0.00	0.86	Baa1	BBB+	A-
CALOPTIMA S1-3	92343VCC6	VERIZON COMMUNICATIONS INC	3.450% 03/15/2021 DD 03/17/14	Corporates	1350000	1363069.46	2070	1369528.2	6458.74	0	0.86	Baa1	BBB+	A-

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MetLife Investment Management

Source Account Name	Security ID	Security Description 1	Security Description 2	Sector	Shares/Par	Base Cost	Accrued Interest	Base Market Value	Base Unrealized Gain	Base Unrealized Loss	Percent of Asset	Moody's Rating	S&P Rating	Fitch Rating
CALOPTIMA S1-3	95000U2B8	WELLS FARGO & CO	2.625% 07/22/2022 DD 07/24/17	Corporates	1500000	1521386.32	7546.87	1,555,197.06	33810.74	0	0.98	A2	BBB+	A+
CALOPTIMA S1-3	95000U2B8	WELLS FARGO & CO	2.625% 07/22/2022 DD 07/24/17	Corporates	750000	760760.16	3773.44	777598.53	16838.37	0	0.49	A2	BBB+	A+
CALOPTIMA S1-3	04609QAC3	ASSOCIATION OF AMERICAN MEDICA	1.926% 10/01/2022 DD 01/29/20	Municipals	1,170,000.0000	1,170,000.00	11,267.10	1,184,289.99	14,289.99	0.00	0.75	NR	A+	AA
CALOPTIMA S1-3	072024WW8	BAY AREA CA TOLL AUTH TOLL BRI	2.128% 04/01/2022 DD 09/26/19	Municipals	1,145,000.0000	1,145,000.00	12,182.80	1,170,419.00	25,419.00	0.00	0.74	A1	AA-	AA-
CALOPTIMA S1-3	072024WW8	BAY AREA CA TOLL AUTH TOLL BRI	2.128% 04/01/2022 DD 09/26/19	Municipals	425,000.0000	426,636.12	4,522.00	434,435.00	7,798.88	0.00	0.27	A1	AA-	AA-
CALOPTIMA S1-3	072722AA9	BAYCARE HEALTH SYSTEM INC	2.460% 11/15/2020 DD 04/16/20	Municipals	335,000.0000	335,000.00	3,777.13	335,000.00	0.00	0.00	0.21	Aa2	NR	AA
CALOPTIMA S1-3	072722AC5	BAYCARE HEALTH SYSTEM INC	2.610% 11/15/2022 DD 04/16/20	Municipals	560,000.0000	565,301.60	6,699.00	585,799.65	20,498.05	0.00	0.37	Aa2	NR	AA
CALOPTIMA S1-3	130179RQ9	CALIFORNIA ST EDUCTNL FACS AUT	3.258% 10/01/2020 DD 11/21/18	Municipals	820,000.0000	820,000.00	13,357.80	820,000.00	0.00	0.00	0.52	A2	NR	NR
CALOPTIMA S1-3	13032UUY2	CALIFORNIA ST HLTH FACS FING A	1.896% 06/01/2021 DD 11/25/19	Municipals	860,000.0000	860,000.00	5,435.20	867,464.80	7,464.80	0.00	0.55	Aa3	AA-	AA-
CALOPTIMA S1-3	13063DLZ9	CALIFORNIA ST	3.000% 04/01/2024 DD 04/04/19	Municipals	1,235,000.0000	1,282,237.08	18,525.00	1,336,097.10	53,860.02	0.00	0.84	Aa2	AA-	AA
CALOPTIMA S1-3	13066YTY5	CALIFORNIA ST DEPT OF WTR RESO	1.713% 05/01/2021 DD 09/28/16	Municipals	879,438.7100	879,438.71	6,276.99	886,922.73	7,484.02	0.00	0.56	NR	AA+	NR
CALOPTIMA S1-3	13067WRB0	CALIFORNIA ST DEPT OF WTR RESO	0.560% 12/01/2024 DD 08/06/20	Municipals	825,000.0000	825,000.00	705.83	826,146.75	1,146.75	0.00	0.52	Aa1	AAA	NR
CALOPTIMA S1-3	157432KA2	CHAFFEY CA CMNTY CLG DIST	1.606% 06/01/2022 DD 09/24/19	Municipals	285,000.0000	285,000.00	1,525.70	289,802.25	4,802.25	0.00	0.18	Aa2	AA	NR
CALOPTIMA S1-3	190335HF9	COAST CA CMNTY CLG DIST	1.556% 08/01/2021 DD 08/31/16	Municipals	585,000.0000	585,000.00	1,517.10	590,288.40	5,288.40	0.00	0.37	Aa1	AA+	NR
CALOPTIMA S1-3	283062DL8	EL DORADO CA IRR DIST REVENUE	0.871% 03/01/2023 DD 06/23/20	Municipals	280,000.0000	280,000.00	203.23	282,153.20	2,153.20	0.00	0.18	Aa3	AA-	NR
CALOPTIMA S1-3	283062DM6	EL DORADO CA IRR DIST REVENUE	1.080% 03/01/2024 DD 06/23/20	Municipals	280,000.0000	280,000.00	252.00	283,528.00	3,528.00	0.00	0.18	Aa3	AA-	NR
CALOPTIMA S1-3	41978CAV7	HAWAII ST ARPTS SYS CUSTOMER F	1.819% 07/01/2022 DD 08/27/19	Municipals	285,000.0000	285,000.00	1,296.04	285,541.50	541.50	0.00	0.18	A2	A-	A
CALOPTIMA S1-3	41978CAX3	HAWAII ST ARPTS SYS CUSTOMER F	2.008% 07/01/2024 DD 08/27/19	Municipals	285,000.0000	285,000.00	1,430.70	284,851.80	0.00	-148.20	0.18	A2	A-	A
CALOPTIMA S1-3	544587Y28	LOS ANGELES CA MUNI IMPT CORPL	0.515% 11/01/2022 DD 08/20/20	Municipals	350,000.0000	350,000.00	205.28	350,164.50	164.50	0.00	0.22	NR	AA-	NR
CALOPTIMA S1-3	544587Y36	LOS ANGELES CA MUNI IMPT CORPL	0.650% 11/01/2023 DD 08/20/20	Municipals	280,000.0000	280,000.00	207.28	280,327.60	327.60	0.00	0.18	NR	AA-	NR
CALOPTIMA S1-3	576000XB4	MASSACHUSETTS ST SCH BLDG AUTH	1.963% 10/15/2022 DD 11/20/19	Municipals	720,000.0000	720,000.00	6,517.16	739,216.80	19,216.80	0.00	0.47	Aa3	AA	AA+
CALOPTIMA S1-3	576051VW3	MASSACHUSETTS ST WTR RESOURCES	1.772% 08/01/2023 DD 11/01/19	Municipals	945,000.0000	945,000.00	2,790.90	977,867.10	32,867.10	0.00	0.62	Aa1	AA+	AA+
CALOPTIMA S1-3	605581MY0	MISSISSIPPI ST	0.422% 11/01/2023 DD 08/06/20	Municipals	1,770,000.0000	1,770,000.00	1,141.16	1,772,725.80	2,725.80	0.00	1.12	Aa2	AA	AA
CALOPTIMA S1-3	67759HMU5	OHIO ST SPL OBLG	0.564% 10/01/2023 DD 08/12/20	Municipals	460,000.0000	460,000.00	353.13	462,543.80	2,543.80	0.00	0.29	Aa2	AA	AA
CALOPTIMA S1-3	752147HG6	RANCHO SANTIAGO CA CMNTY CLG D	0.415% 09/01/2023 DD 09/02/20	Municipals	335,000.0000	335,000.00	111.99	335,482.40	482.40	0.00	0.21	Aa2	AA	NR
CALOPTIMA S1-3	76913CAW9	RIVERSIDE CNTY CA PENSN OBLG	2.265% 02/15/2022 DD 05/06/20	Municipals	945,000.0000	945,000.00	2,734.99	965,052.90	20,052.90	0.00	0.61	A2	AA	NR
CALOPTIMA S1-3	797272QM6	SAN DIEGO CA CMNTY CLG DIST	1.936% 08/01/2022 DD 10/16/19	Municipals	600,000.0000	600,000.00	1,936.00	615,804.00	15,804.00	0.00	0.39	Aaa	AAA	NR
CALOPTIMA S1-3	797412DL4	SAN DIEGO CNTY CA WTR AUTH	0.593% 05/01/2024 DD 07/22/20	Municipals	560,000.0000	560,000.00	636.49	561,377.60	1,377.60	0.00	0.35	Aa2	AAA	AA+
CALOPTIMA S1-3	797669XV5	SAN FRANCISCO CA BAY AREA RAPI	2.537% 07/01/2022 DD 12/28/17	Municipals	570,000.0000	577,704.27	3,615.23	589,283.10	11,578.83	0.00	0.37	NR	AA+	AA+
CALOPTIMA S1-3	79766DSS9	SAN FRANCISCO CALIF CITY &CNTY	1.782% 05/01/2022 DD 09/10/19	Municipals	845,000.0000	840,056.85	6,274.13	854,455.55	14,398.70	0.00	0.54	A1	A	A+
CALOPTIMA S1-3	79766DST7	SAN FRANCISCO CALIF CITY &CNTY	1.867% 05/01/2023 DD 09/10/19	Municipals	645,000.0000	638,389.37	5,017.56	656,487.45	18,098.08	0.00	0.41	A1	A	A+
CALOPTIMA S1-3	798189RC2	SAN JOSE CA EVERGREEN CMNTY CL	0.598% 09/01/2021 DD 06/16/20	Municipals	110,000.0000	110,000.00	191.86	110,193.60	193.60	0.00	0.07	Aa1	AA+	NR
CALOPTIMA S1-3	798189RD0	SAN JOSE CA EVERGREEN CMNTY CL	0.698% 09/01/2022 DD 06/16/20	Municipals	170,000.0000	170,000.00	346.09	170,836.40	836.40	0.00	0.11	Aa1	AA+	NR
CALOPTIMA S1-3	882724QX8	TEXAS ST	1.614% 10/01/2022 DD 04/23/20	Municipals	915,000.0000	915,000.00	6,481.56	939,650.10	24,650.10	0.00	0.59	Aaa	AAA	NR
CALOPTIMA S1-3	913366HV5	UNIV OF CALIFORNIA CA RGTS MED	1.620% 05/15/2021 DD 08/17/16	Municipals	485,000.0000	483,182.00	2,968.20	488,104.00	4,922.00	0.00	0.31	Aa3	AA-	AA-
CALOPTIMA S1-3	916544ES4	UPPER SANTA CLARA VY CA JT PWR	0.680% 08/01/2023 DD 07/23/20	Municipals	1,010,000.0000	1,010,000.00	1,297.29	1,011,060.50	1,060.50	0.00	0.64	NR	AA	AA-
CALOPTIMA S1-3	916544ET2	UPPER SANTA CLARA VY CA JT PWR	0.827% 08/01/2024 DD 07/23/20	Municipals	1,025,000.0000	1,025,000.00	1,601.16	1,026,558.00	1,558.00	0.00	0.65	NR	AA	AA-
CALOPTIMA S1-3	9174367H4	UTAH ST HSG CORP SF MTGE REVEN	2.100% 01/01/2022 DD 10/02/19	Municipals	620,000.0000	620,000.00	3,255.00	626,076.00	6,076.00	0.00	0.39	Aa2	NR	NR
CALOPTIMA S1-3	9174367J0	UTAH ST HSG CORP SF MTGE REVEN	2.150% 07/01/2022 DD 10/02/19	Municipals	255,000.0000	255,000.00	1,370.63	258,919.35	3,919.35	0.00	0.16	Aa2	NR	NR
CALOPTIMA S1-3	923078CS6	VENTURA CNTY CA PUBLIC FING AU	0.848% 11/01/2022 DD 06/11/20	Municipals	220,000.0000	220,000.00	570.04	221,434.40	1,434.40	0.00	0.14	Aa1	AA+	NR
CALOPTIMA S1-3	923078CT4	VENTURA CNTY CA PUBLIC FING AU	1.048% 11/01/2023 DD 06/11/20	Municipals	280,000.0000	280,000.00	896.62	283,721.20	3,721.20	0.00	0.18	Aa1	AA+	NR
CALOPTIMA S1-3	923078CT4	VENTURA CNTY CA PUBLIC FING AU	1.048% 11/01/2023 DD 06/11/20	Municipals	280000	281001.14	896.62	283721.2	2720.06	0	0.18	Aa1	AA+	NR
CALOPTIMA S1-3	3128M1B99	FHLMC POOL #G1-1964	5.000% 04/01/2021 DD 03/01/06	RMBS	1,863.0830	1,863.34	7.76	1,961.99	98.65	0.00	0.00	Agency	AA+	Agency
CALOPTIMA S1-3	3128MBQD2	FHLMC POOL #G1-2952	6.000% 12/01/2022 DD 12/01/07	RMBS	67,309.7910	68,701.83	336.55	69,638.03	936.20	0.00	0.04	Agency	AA+	Agency
CALOPTIMA S1-3	3128MMKR3	FHLMC POOL #G1-8303	4.500% 03/01/2024 DD 03/01/09	RMBS	156,581.4890	160,927.99	587.18	165,590.42	4,662.43	0.00	0.10	Agency	AA+	Agency
CALOPTIMA S1-3	3134GV6H6	FEDERAL HOME LN MTG CORP	0.320% 10/20/2022 DD 07/20/20	RMBS	2,000,000.0000	1,999,451.84	1,262.22	2,001,138.48	1,686.64	0.00	1.26	Agency	AA+	Agency
CALOPTIMA S1-3	3134GWGB6	FEDERAL HOME LN MTG CORP	0.450% 07/28/2023 DD 07/28/20	RMBS	1,200,000.0000	1,200,000.00	945.00	1,200,421.58	421.58	0.00	0.76	Agency	AA+	Agency
CALOPTIMA S1-3	3134GWGB6	FEDERAL HOME LN MTG CORP	0.450% 07/28/2023 DD 07/28/20	RMBS	800,000.0000	800,000.00	630.00	800,281.06	281.06	0.00	0.50	Agency	AA+	Agency
CALOPTIMA S1-3	3134GWND4	FEDERAL HOME LN MTG CORP	0.600% 08/12/2025 DD 08/12/20	RMBS	1,600,000.0000	1,598,286.06	1,306.67	1,596,737.22	0.00	-1,548.84	1.01	Agency	AA+	Agency
CALOPTIMA S1-3	3134GWTL0	FEDERAL HOME LN MTG CORP	0.300% 09/28/2023 DD 09/28/20	RMBS	1,595,000.0000	1,594,761.41	39.88	1,594,017.35	0.00	-744.06	1.00	Agency	AA+	Agency
CALOPTIMA S1-3	3135G0S38	FEDERAL NATL MTG ASSN	2.000% 01/05/2022 DD 01/09/17	RMBS	3,400,000.0000	3,403,275.58	16,244.44	3,481,051.04	77,775.46	0.00	2.19	Agency	AA+	Agency
CALOPTIMA S1-3	3135G0S38	FEDERAL NATL MTG ASSN	2.000% 01/05/2022 DD 01/09/17	RMBS	2,250,000.0000	2,255,573.94	10,750.00	2,303,636.71	48,062.77	0.00	1.45	Agency	AA+	Agency
CALOPTIMA S1-3	3136A5KR6	FNMA GTD REMIC P/T 12-31 AD	1.750% 10/25/2022 DD 03/01/12	RMBS	89,458.6450	88,700.95	130.46	89,603.42	902.47	0.00	0.06	Agency	AA+	Agency
CALOPTIMA S1-3	3136A5KR6	FNMA GTD REMIC P/T 12-31 AD	1.750% 10/25/2022 DD 03/01/12	RMBS	224,783.6090	223,043.60	327.81	225,147.40	2,103.80	0.00	0.14	Agency	AA+	Agency
CALOPTIMA S1-3	3136A5X68	FNMA GTD REMIC P/T 12-50 VA	4.000% 07/25/2023 DD 04/01/12	RMBS	105,186.0460	107,215.08	350.62	107,194.90	0.00	-20.18	0.07	Agency	AA+	Agency
CALOPTIMA S1-3	3136A72D3	FNMA GTD REMIC P/T 12-M9 A2	2.482% 04/25/2022 DD 08/01/12	RMBS	29,045.5450	29,143.60	60.08	29,569.83	426.23	0.00	0.02	Agency	AA+	Agency
CALOPTIMA S1-3	3136A72D3	FNMA GTD REMIC P/T 12-M9 A2	2.482% 04/25/2022 DD 08/01/12	RMBS	147,462.0100	147,964.13	305.00	150,123.74	2,159.61	0.00	0.09	Agency	AA+	Agency
CALOPTIMA S1-3	3136AHVQ0	FNMA GTD REMIC P/T 13-136 CV	3.500% 06/25/2023 DD 12/01/13	RMBS	142,519.6450	144,795.90	415.68	145,319.89	523.99	0.00	0.09	Agency	AA+	Agency
CALOPTIMA S1-3	3137A2PV7	FHLMC MULTICLASS MTG 3760 BA	1.500% 09/15/2022 DD 11/01/10	RMBS	134,451.8720	133,027.61	168.06	135,437.16	2,409.55	0.00	0.09	Agency	AA+	Agency
CALOPTIMA S1-3	3137APP61	FHLMC MULTICLASS MTG K018 A2	2.789% 01/25/2022 DD 05/01/12	RMBS	118,816.5960	119,847.48	276.15	121,720.57	1,873.09	0.00	0.08	Agency	AA+	AAA
CALOPTIMA S1-3	3137APP61	FHLMC MULTICLASS MTG K018 A2	2.789% 01/25/2022 DD 05/01/12	RMBS	31,989.0840	32,250.86	74.35	32,770.92	520.06	0.00	0.02	Agency	AA+	AAA
CALOPTIMA S1-3	3137AXHP1	FHLMC MULTICLASS MTG K024 A2	2.573% 09/25/2022 DD 01/01/13	RMBS	965,000.0000	971,209.59	2,069.12	1,001,493.79	30,284.20	0.00	0.63	Aaa	AA+	Agency
CALOPTIMA S1-3	3137AXHP1	FHLMC MULTICLASS MTG K024 A2	2.573% 09/25/2022 DD 01/01/13	RMBS	700,000.0000	704,304.77	1,500.92	726,472.18	22,167.41	0.00	0.46	Aaa	AA+	Agency
CALOPTIMA S1-3	3137AYCE9	FHLMC MULTICLASS MTG K025 A2	2.682% 10/25/2022 DD 02/01/13	RMBS	1,425,000.0000	1,445,191.00	3,184.88	1,479,604.29	34,413.29	0.00	0.93	Aaa	AA+	Agency
CALOPTIMA S1-3	3137AYCE9	FHLMC MULTICLASS MTG K025 A2	2.682% 10/25/2022 DD 02/01/13	RMBS	200,000.0000	202,831.44	447.00	207,663.76	4,832.32	0.00	0.13	Aaa	AA+	Agency
CALOPTIMA S1-3	3137B04Y7	FHLMC MULTICLASS MTG KSMC A2	2.615% 01/25/2023 DD 03/01/13	RMBS	750,000.0000	758,904.83	1,634.38	787,791.00	28,886.17	0.00	0.50	Agency	AA+	Agency

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MetLife Investment Management

Source Account Name	Security ID	Security Description 1	Security Description 2	Sector	Shares/Par	Base Cost	Accrued Interest	Base Market Value	Base Unrealized Gain	Base Unrealized Loss	Percent of Asset	Moody's Rating	S&P Rating	Fitch Rating
CALOPTIMA S1-3	3137B1UG5	FHLMC MULTICLASS MTG K027 A2	2.637% 01/25/2023 DD 05/01/13	RMBS	840,000.0000	840,386.93	1,845.90	875,090.83	34,703.90	0.00	0.55	Agency	AA+	AAA
CALOPTIMA S1-3	3137B1UG5	FHLMC MULTICLASS MTG K027 A2	2.637% 01/25/2023 DD 05/01/13	RMBS	1,000,000.0000	1,000,121.62	2,197.50	1,041,774.80	41,653.18	0.00	0.66	Agency	AA+	AAA
CALOPTIMA S1-3	3137B2ZH6	FHLMC MULTICLASS MTG 4221 HJ	1.500% 07/15/2023 DD 06/01/13	RMBS	177,252.7380	176,269.67	221.57	178,738.95	2,469.28	0.00	0.11	Agency	AA+	Agency
CALOPTIMA S1-3	3137B6RG8	FHLMC MULTICLASS MTG 4285 BA	2.000% 12/15/2023 DD 12/01/13	RMBS	254,931.6420	259,625.39	424.89	259,557.96	0.00	-67.43	0.16	Agency	AA+	Agency
CALOPTIMA S1-3	3137B7MZ9	FHLMC MULTICLASS MTG K036 A2	VAR RT 10/25/2023 DD 02/01/14	RMBS	680,000.0000	739,550.65	1,998.63	737,571.45	0.00	-1,979.20	0.46	Aaa	AA+	AAA
CALOPTIMA S1-3	3137BFE80	FHLMC MULTICLASS MTG K041 A1	2.720% 08/25/2024 DD 12/01/14	RMBS	2,899,302.2960	3,021,526.61	6,571.75	3,018,760.80	0.00	-2,765.81	1.90	Agency	AA+	AAA
CALOPTIMA S1-3	3137EADB2	FEDERAL HOME LN MTG CORP	2.375% 01/13/2022 DD 01/13/12	RMBS	2,250,000.0000	2,265,999.92	11,578.12	2,314,947.99	48,948.07	0.00	1.46	Agency	AA+	Agency
CALOPTIMA S1-3	3137EADB2	FEDERAL HOME LN MTG CORP	2.375% 01/13/2022 DD 01/13/12	RMBS	2,250,000.0000	2,273,652.30	11,578.13	2,314,947.98	41,295.68	0.00	1.46	Agency	AA+	Agency
CALOPTIMA S1-3	3137EAEV7	FEDERAL HOME LN MTG CORP	0.250% 08/24/2023 DD 08/21/20	RMBS	3,200,000.0000	3,196,856.54	888.89	3,202,169.95	5,313.41	0.00	2.02	Agency	AA+	Agency
CALOPTIMA S1-3	31393A2V8	FNMA GTD REMIC P/T 03-38 MP	5.500% 05/25/2023 DD 04/01/03	RMBS	100,146.9740	102,811.68	459.01	104,493.21	1,681.53	0.00	0.07	Agency	AA+	Agency
CALOPTIMA S1-3	31393DLQ2	FNMA GTD REMIC P/T 03-64 HQ	5.000% 07/25/2023 DD 06/01/03	RMBS	160,216.8550	163,810.13	667.57	166,859.01	3,048.88	0.00	0.11	Agency	AA+	Agency
CALOPTIMA S1-3	31394PWU3	FHLMC MULTICLASS MTG 2756 KA	5.000% 02/15/2024 DD 02/01/04	RMBS	174,895.6700	181,787.76	728.73	181,679.33	0.00	-108.43	0.11	Agency	AA+	Agency
CALOPTIMA S1-3	31397UPF0	FNMA GTD REMIC P/T 11-M1 A3	3.763% 06/25/2021 DD 05/01/11	RMBS	85,876.7200	86,286.26	269.30	86,809.71	523.45	0.00	0.05	Agency	AA+	Agency
CALOPTIMA S1-3	62888UAB6	NCUA GUARANTEED NOTES TR R2 2A	VAR RT 11/05/2020 DD 11/17/10	RMBS	265,325.7970	265,349.69	110.51	265,331.00	0.00	-18.69	0.17	Aaa	AA+	Agency
CALOPTIMA S1-3	92261WAB6	VENDEE MORTGAGE TRUST 201 1 DV	3.750% 06/15/2022 DD 04/01/11	RMBS	92,608.9050	93,552.87	289.40	94,862.62	1,309.75	0.00	0.06	Agency	AA+	Agency
CALOPTIMA S1-3	9128285H9	U S TREASURY NOTE	VAR RT 10/31/2020 DD 10/31/18	US Government	2,000,000.0000	2,000,081.62	515.65	2,000,046.90	0.00	-34.72	1.26	Govt	AA+	Govt
CALOPTIMA S1-3	9128284H0	US TREAS-CPI INFLAT	0.625%004/15/2023 DD 04/15/18	US Government	1,355,822.0000	1,362,362.63	3,912.81	1,418,634.68	56,272.05	0.00	0.89	Govt	AA+	Govt
CALOPTIMA S1-3	9128286N5	US TREAS-CPI INFLAT	0.500% 04/15/2024 DD 04/15/19	US Government	883,276.2700	892,827.26	2,039.26	937,848.48	45,021.22	0.00	0.59	Govt	AA+	Govt
CALOPTIMA S1-3	9128286N5	US TREAS-CPI INFLAT	0.500% 04/15/2024 DD 04/15/19	US Government	1,525,386.8820	1,543,355.11	3,521.73	1,619,631.16	76,276.05	0.00	1.02	Govt	AA+	Govt
CALOPTIMA S1-3	9128286N5	US TREAS-CPI INFLAT	0.500% 04/15/2024 DD 04/15/19	US Government	760,125.4480	771,413.96	1,754.93	807,088.92	35,674.96	0.00	0.51	Govt	AA+	Govt
CALOPTIMA S1-3	9128286U9	U S TREASURY NOTE	2.125% 05/15/2022 DD 05/15/19	US Government	1,520,000.0000	1,531,621.42	12,200.27	1,569,281.26	37,659.84	0.00	0.99	Govt	AA+	Govt
CALOPTIMA S1-3	9128286U9	U S TREASURY NOTE	2.125% 05/15/2022 DD 05/15/19	US Government	4,560,000.0000	4,593,534.16	36,600.81	4,707,843.77	114,309.61	0.00	2.97	Govt	AA+	Govt
CALOPTIMA S1-3	9128286U9	U S TREASURY NOTE	2.125% 05/15/2022 DD 05/15/19	US Government	760,000.0000	766,452.50	6,100.14	784,640.63	18,188.13	0.00	0.49	Govt	AA+	Govt
CALOPTIMA S1-3	9128286U9	U S TREASURY NOTE	2.125% 05/15/2022 DD 05/15/19	US Government	2,810,000.0000	2,842,293.13	22,554.45	2,901,105.48	58,812.35	0.00	1.83	Govt	AA+	Govt
CALOPTIMA S1-3	9128286U9	U S TREASURY NOTE	2.125% 05/15/2022 DD 05/15/19	US Government	300,000.0000	303,310.66	2,407.95	309,726.57	6,415.91	0.00	0.20	Govt	AA+	Govt
CALOPTIMA S1-3	912828J43	U S TREASURY NOTE	1.750% 02/28/2022 DD 02/28/15	US Government	1,530,000.0000	1,532,403.59	2,292.89	1,565,022.65	32,619.06	0.00	0.99	Govt	AA+	Govt
CALOPTIMA S1-3	912828J43	U S TREASURY NOTE	1.750% 02/28/2022 DD 02/28/15	US Government	5,000.0000	5,008.58	7.49	5,114.45	105.87	0.00	0.00	Govt	AA+	Govt
CALOPTIMA S1-3	912828J43	U S TREASURY NOTE	1.750% 02/28/2022 DD 02/28/15	US Government	2,295,000.0000	2,301,692.21	3,439.33	2,347,533.97	45,841.76	0.00	1.48	Govt	AA+	Govt
CALOPTIMA S1-3	912828J43	U S TREASURY NOTE	1.750% 02/28/2022 DD 02/28/15	US Government	1,525,000.0000	1,527,146.46	2,285.39	1,559,908.20	32,761.74	0.00	0.98	Govt	AA+	Govt
CALOPTIMA S1-3	912828L57	U S TREASURY NOTE	1.750% 09/30/2022 DD 09/30/15	US Government	750,000.0000	753,159.20	36.05	774,257.81	21,098.61	0.00	0.49	Govt	AA+	Govt
CALOPTIMA S1-3	912828L57	U S TREASURY NOTE	1.750% 09/30/2022 DD 09/30/15	US Government	3,740,000.0000	3,753,448.41	179.81	3,860,965.63	107,517.22	0.00	2.43	Govt	AA+	Govt
CALOPTIMA S1-3	912828L57	U S TREASURY NOTE	1.750% 09/30/2022 DD 09/30/15	US Government	3,100,000.0000	3,112,821.22	149.04	3,200,265.63	87,444.41	0.00	2.02	Govt	AA+	Govt
CALOPTIMA S1-3	912828L57	U S TREASURY NOTE	1.750% 09/30/2022 DD 09/30/15	US Government	4,675,000.0000	4,699,656.64	224.76	4,826,207.03	126,550.39	0.00	3.04	Govt	AA+	Govt
CALOPTIMA S1-3	912828L57	U S TREASURY NOTE	1.750% 09/30/2022 DD 09/30/15	US Government	500,000.0000	501,577.71	24.04	516,171.88	14,594.17	0.00	0.33	Govt	AA+	Govt
CALOPTIMA S1-3	912828L57	U S TREASURY NOTE	1.750% 09/30/2022 DD 09/30/15	US Government	765,000.0000	766,611.75	36.78	789,742.96	23,131.21	0.00	0.50	Govt	AA+	Govt
CALOPTIMA S1-3	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	1,235,000.0000	1,228,031.68	7,841.07	1,266,309.18	38,277.50	0.00	0.80	Govt	AA+	Govt
CALOPTIMA S1-3	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	2,350,000.0000	2,347,701.05	14,920.25	2,409,576.16	61,875.11	0.00	1.52	Govt	AA+	Govt

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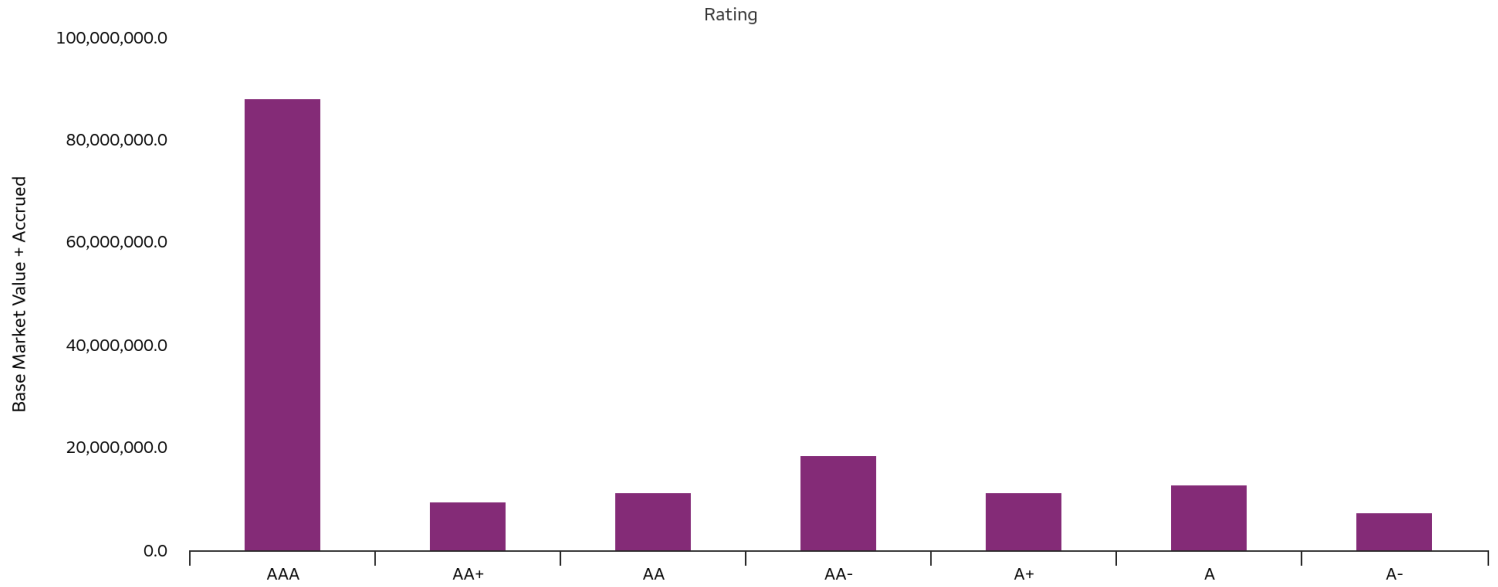
Credit Rating

US Dollar

As of 30 September 2020

WC-CalOptima - Tier One
Account: XXXX2501
Investment Strategy: Short Duration Fixed Income
Primary Benchmark: ICE BofA 1-3 Year US Treasury Index



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Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
05522RCZ9 BACCT 2018-2 A	1,000,000.00	USD 09/15/2023	ABS	AAA	Aaa	AAA	NA	1,016,253.93	0.64%
05588CAC6 BMWOT 2019-A A3	730,000.00	USD 01/25/2024	ABS	AAA	NA	AAA	AAA	743,435.58	0.47%
14041NFU0 COMET 2019-2 A	1,000,000.00	USD 09/15/2022	ABS	AAA	NA	AAA	AAA	1,028,081.94	0.64%
14042WAC4 COPAR 2019-1 A3	1,500,000.00	USD 11/15/2023	ABS	AAA	Aaa	AAA	AAA	1,535,736.68	0.96%
14043MAC5 COPAR 2020-1 A3	1,000,000.00	USD 11/15/2024	ABS	AAA	NA	AAA	AAA	1,022,854.71	0.64%
3130AF5B9 FEDERAL HOME LOAN BANKS	1,000,000.00	USD 10/12/2021	AGCY BOND	AAA	Aaa	AA+	AAA	1,043,559.12	0.65%
313380GJ0 FEDERAL HOME LOAN BANKS	2,950,000.00	USD 09/09/2022	AGCY BOND	AAA	Aaa	AA+	AAA	3,060,321.54	1.92%
3133EJ5P0 FEDERAL FARM CREDIT BANKS FUNDING CORP	3,000,000.00	USD 01/18/2022	AGCY BOND	AAA	Aaa	AA+	AAA	3,110,409.79	1.95%
3133EKVD5 FEDERAL FARM CREDIT BANKS FUNDING CORP	4,400,000.00	USD 01/18/2022	AGCY BOND	AAA	Aaa	AA+	AAA	4,514,878.87	2.83%

The information contained in this report represents estimated trade date investment calculations. Certain calculations may not be available for all time periods. Please refer to your custody statement for official portfolio holdings and transactions. Note that certain accounting methods may cause differences between this investment report and your custody statement.

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Credit Rating

US Dollar

As of 30 September 2020

WC-CalOptima - Tier One
Account: XXXX2501
Investment Strategy: Short Duration Fixed Income
Primary Benchmark: ICE BofA 1-3 Year US Treasury Index

WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
3135G05G4 FEDERAL NATIONAL MORTGAGE ASSOCIATION	1,000,000.00	USD 07/10/2023	AGCY BOND	AAA	Aaa	AA+	AAA	1,000,356.55	0.63%
3137AN2K0 FHR 4019 EV	858,821.99	USD 06/15/2023	FHLMC CMO	AAA	Aaa	AA+	AAA	894,217.97	0.56%
3137APP61 FHMS K-018 A2	1,188,165.89	USD 01/25/2022	FHLMC	AAA	Aaa	AA+	AAA	1,219,967.11	0.76%
3137BFDQ1 FHMS K-717 A2	1,133,188.56	USD 09/25/2021	FHLMC	AAA	Aaa	AA+	AAA	1,156,116.03	0.72%
3137EAEV7 FEDERAL HOME LOAN MORTGAGE CORP	1,000,000.00	USD 08/24/2023	AGCY BOND	AAA	Aaa	AA+	AAA	1,000,955.89	0.63%
3137EAEW5 FEDERAL HOME LOAN MORTGAGE CORP	1,150,000.00	USD 09/08/2023	AGCY BOND	AAA	Aaa	AA+	AAA	1,150,636.33	0.72%
316175108 FIDELITY IMM:GOVT I	2,163,695.13	USD 09/30/2020	MMFUND	AAA	Aaa	AAAm	AAA	2,163,695.13	1.35%
43814WAC9 HAROT 2019-1 A3	1,330,000.00	USD 03/20/2023	ABS	AAA	NA	AAA	AAA	1,360,596.71	0.85%
4581X0DM7 INTER-AMERICAN DEVELOPMENT BANK	2,000,000.00	USD 05/24/2023	SUPRANATIONAL	AAA	Aaa	AAA	NA	2,016,307.78	1.26%
459058GH0 INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPM	1,500,000.00	USD 07/23/2021	SUPRANATIONAL	AAA	Aaa	AAA	NA	1,538,691.67	0.96%
47789JAD8 JDOT 2019 A3	2,100,000.00	USD 07/17/2023	ABS	AAA	Aaa	NA	AAA	2,150,006.32	1.35%
58769EAC2 MBALT 2020-B A3	740,000.00	USD 11/15/2023	ABS	AAA	NA	AAA	AAA	740,065.78	0.46%
58770FAC6 MBALT 2020-A A3	1,295,000.00	USD 12/15/2022	ABS	AAA	Aaa	AAA	NA	1,317,145.64	0.82%
797272QL8 SAN DIEGO CALIF CMNTY COLLEGE DIST	1,500,000.00	USD 08/01/2021	MUNI	AAA	Aaa	AAA	NA	1,523,482.50	0.95%
9128285L0 UNITED STATES TREASURY	775,000.00	USD 11/15/2021	US GOV	AAA	Aaa	AA+	AAA	807,210.84	0.51%
9128285V8 UNITED STATES TREASURY	3,000,000.00	USD 01/15/2022	US GOV	AAA	Aaa	AA+	AAA	3,107,303.74	1.94%
9128285V8 UNITED STATES TREASURY	4,000,000.00	USD 01/15/2022	US GOV	AAA	Aaa	AA+	AAA	4,143,071.65	2.59%
9128286C9 UNITED STATES TREASURY	2,950,000.00	USD 02/15/2022	US GOV	AAA	Aaa	AA+	AAA	3,055,294.16	1.91%
9128286C9 UNITED STATES TREASURY	2,160,000.00	USD 02/15/2022	US GOV	AAA	Aaa	AA+	AAA	2,237,096.74	1.40%
9128286C9 UNITED STATES TREASURY	2,500,000.00	USD 02/15/2022	US GOV	AAA	Aaa	AA+	AAA	2,589,232.34	1.62%
9128286M7 UNITED STATES TREASURY	475,000.00	USD 04/15/2022	US GOV	AAA	Aaa	AA+	AAA	495,446.54	0.31%

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Credit Rating

US Dollar

As of 30 September 2020

WC-CalOptima - Tier One
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WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
9128286U9 UNITED STATES TREASURY	1,670,000.00	USD 05/15/2022	US GOV	AAA	Aaa	AA+	AAA	1,737,548.99	1.09%
9128286U9 UNITED STATES TREASURY	2,700,000.00	USD 05/15/2022	US GOV	AAA	Aaa	AA+	AAA	2,809,210.94	1.76%
9128286U9 UNITED STATES TREASURY	900,000.00	USD 05/15/2022	US GOV	AAA	Aaa	AA+	AAA	936,403.65	0.59%
9128286U9 UNITED STATES TREASURY	1,400,000.00	USD 05/15/2022	US GOV	AAA	Aaa	AA+	AAA	1,456,627.89	0.91%
9128286U9 UNITED STATES TREASURY	4,800,000.00	USD 05/15/2022	US GOV	AAA	Aaa	AA+	AAA	4,994,152.77	3.13%
912828P38 UNITED STATES TREASURY	1,300,000.00	USD 01/31/2023	US GOV	AAA	Aaa	AA+	AAA	1,352,532.18	0.85%
912828P38 UNITED STATES TREASURY	5,100,000.00	USD 01/31/2023	US GOV	AAA	Aaa	AA+	AAA	5,306,087.78	3.32%
912828TY6 UNITED STATES TREASURY	2,000,000.00	USD 11/15/2022	US GOV	AAA	Aaa	AA+	AAA	2,075,399.82	1.30%
912828TY6 UNITED STATES TREASURY	1,500,000.00	USD 11/15/2022	US GOV	AAA	Aaa	AA+	AAA	1,556,549.86	0.97%
912828YA2 UNITED STATES TREASURY	1,900,000.00	USD 08/15/2022	US GOV	AAA	Aaa	AA+	AAA	1,952,623.85	1.22%
912828YW4 UNITED STATES TREASURY	4,500,000.00	USD 12/15/2022	US GOV	AAA	Aaa	AA+	AAA	4,669,587.37	2.92%
912828ZH6 UNITED STATES TREASURY	250,000.00	USD 04/15/2023	US GOV	AAA	Aaa	AA+	AAA	250,962.34	0.16%
91282CAG6 UNITED STATES TREASURY	2,725,000.00	USD 08/31/2022	US GOV	AAA	Aaa	AA+	AAA	2,725,185.42	1.71%
91282CAK7 UNITED STATES TREASURY	1,400,000.00	USD 09/15/2023	US GOV	AAA	Aaa	AA+	AAA	1,398,874.75	0.88%
91282CAK7 UNITED STATES TREASURY	4,000,000.00	USD 09/15/2023	US GOV	AAA	Aaa	AA+	AAA	3,996,784.99	2.50%
CCYUSD Cash	-499,999.20	USD 09/30/2020	CASH	AAA	Aaa	AAA	AAA	-499,999.20	-0.31%
CCYUSD Receivable	2,968,638.56	USD 09/30/2020	CASH	AAA	Aaa	AAA	AAA	2,968,638.56	1.86%
CCYUSD Payable	-4,275,667.50	USD 09/30/2020	CASH	AAA	Aaa	AAA	AAA	-4,275,667.50	-2.68%
--- ---	**85,736,843.43**	**USD 09/06/2022**	---	**AAA**	**Aaa**	**AA+**	**AAA**	**88,153,934.01**	**55.17%**

AA+

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WELLS FARGO Asset Management

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037833DL1 APPLE INC	250,000.00	USD 09/11/2022	CORP	AA+	Aa1	AA+	NA	257,007.09	0.16%
037833DL1 APPLE INC	500,000.00	USD 09/11/2022	CORP	AA+	Aa1	AA+	NA	514,014.18	0.32%
037833DV9 APPLE INC	1,200,000.00	USD 05/11/2023	CORP	AA+	Aa1	AA+	NA	1,215,740.96	0.76%
212204JB8 CONTRA COSTA CALIF CMNTY COLLEGE DIST	1,365,000.00	USD 08/01/2021	MUNI	AA+	Aa1	AA+	NA	1,382,881.50	0.87%
212204JC6 CONTRA COSTA CALIF CMNTY COLLEGE DIST	1,000,000.00	USD 08/01/2022	MUNI	AA+	Aa1	AA+	NA	1,023,003.33	0.64%
601670MF6 MILPITAS CALIF UNI SCH DIST	600,000.00	USD 08/01/2023	MUNI	AA+	Aa1	NA	NA	602,188.00	0.38%
677765GS2 OHLONE CALIF CMNTY COLLEGE DIST	1,000,000.00	USD 08/01/2021	MUNI	AA+	Aa1	AA+	NA	1,013,183.33	0.63%
80168ACP0 SANTA CLARA VY CALIF WTR DIST WTR SYS REV	570,000.00	USD 06/01/2022	MUNI	AA+	Aa1	NA	AA+	585,025.20	0.37%
92348XAC9 VZOT 2018-A B	2,925,000.00	USD 04/20/2023	ABS	AA+	Aa1	AA+	AA	3,036,599.21	1.90%
--- ---	**9,410,000.00**	**USD 09/20/2022**	---	**AA+**	**Aa1**	**AA+**	**AA**	**9,629,642.81**	**6.03%**

AA

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
084670BR8 BERKSHIRE HATHAWAY INC	2,000,000.00	USD 03/15/2023	CORP	AA	Aa2	AA	A+	2,109,228.90	1.32%
13079XBR6 CALIFORNIA STATEWIDE CMNTYS DEV AUTH TRANSN REV CT	500,000.00	USD 06/01/2023	MUNI	AA	NA	AA	NA	500,055.00	0.31%
166756AJ5 CHEVRON USA INC	2,500,000.00	USD 08/11/2023	CORP	AA	Aa2	AA	NA	2,503,892.41	1.57%
30231GBB7 EXXON MOBIL CORP	530,000.00	USD 08/16/2022	CORP	AA	Aa1	AA	NA	546,959.33	0.34%
30231GBL5 EXXON MOBIL CORP	1,500,000.00	USD 04/15/2023	CORP	AA	Aa1	AA	NA	1,553,721.08	0.97%
702274CN9 PASADENA CALIF PUB FING AUTH LEASE REV	1,100,000.00	USD 12/01/2022	MUNI	AA	NA	AA+	AA	1,178,503.33	0.74%
79730CJF2 SAN DIEGO CALIF PUB FACS FING AUTH WTR REV	1,000,000.00	USD 08/01/2022	MUNI	AA	Aa2	NA	AA	1,017,031.67	0.64%
931142EJ8 WALMART INC	2,000,000.00	USD 06/23/2021	CORP	AA	Aa2	AA	AA	2,060,397.61	1.29%

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WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
--- ---	11,130,000.00	USD 11/21/2022	---	AA	Aa2	AA	AA-	11,469,789.33	7.18%

AA-

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
032556GN6 ANAHEIM CALIF HSG & PUB IMPT AUTH REV	630,000.00	USD 10/01/2022	MUNI	AA-	NA	AA-	AA-	648,522.16	0.41%
072024WW8 BAY AREA TOLL AUTH CALIF TOLL BRDG REV	2,000,000.00	USD 04/01/2022	MUNI	AA-	A1	AA-	AA-	2,065,680.00	1.29%
3582326R2 FRESNO CALIF UNI SCH DIST	500,000.00	USD 08/01/2023	MUNI	AA-	Aa3	NA	NA	499,861.42	0.31%
376087FX5 GILROY CALIF UNI SCH DIST	500,000.00	USD 08/01/2022	MUNI	AA-	Aa3	AA-	NA	511,318.33	0.32%
544647BE9 LOS ANGELES CALIF UNI SCH DIST	1,575,000.00	USD 07/01/2023	MUNI	AA-	Aa3	NA	AA+	1,802,634.75	1.13%
61741GAB6 MORGAN HILL CALIF REDEV AGY SUCCESSOR AGY TAX ALLO	1,400,000.00	USD 09/01/2023	MUNI	AA-	NA	AA-	NA	1,399,818.00	0.88%
738850SV9 POWAY CALIF UNI SCH DIST	1,140,000.00	USD 08/01/2022	MUNI	AA-	NA	AA-	NA	1,170,510.20	0.73%
769059ZY5 RIVERSIDE CALIF UNI SCH DIST	1,000,000.00	USD 02/01/2022	MUNI	AA-	Aa2	AA-	NA	1,019,136.67	0.64%
79727LBQ1 SAN DIEGO CALIF CONVENTION CTR EXPANSION FING AUTH	2,445,000.00	USD 04/15/2023	MUNI	AA-	NA	AA-	AA-	2,486,103.23	1.56%
842475P58 SOUTHERN CALIF PUB PWR AUTH PWR PROJ REV	2,250,000.00	USD 07/01/2023	MUNI	AA-	NA	AA-	AA-	2,254,370.56	1.41%
90331HPA5 US BANK NA	1,350,000.00	USD 02/04/2021	CORP	AA-	A1	AA-	AA-	1,365,880.79	0.85%
90331HPA5 US BANK NA	400,000.00	USD 02/04/2021	CORP	AA-	A1	AA-	AA-	404,705.42	0.25%
913366HW3 UNIV CALIF REGTS MED CTR POOLED REV	1,000,000.00	USD 05/15/2022	MUNI	AA-	Aa3	AA-	AA-	1,027,568.67	0.64%
916544ES4 UPPER SANTA CLARA VY JT PWRS AUTH CALIF REV	1,900,000.00	USD 08/01/2023	MUNI	AA-	NA	AA	AA-	1,904,435.44	1.19%
--- ---	18,090,000.00	USD 11/16/2022	---	AA-	Aa3	AA-	AA-	18,560,545.64	11.61%

Credit Rating

US Dollar

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WELLS FARGO Asset Management

A+

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
023135BP0 AMAZON.COM INC	1,000,000.00	USD 06/03/2023	CORP	A+	A2	AA-	A+	1,005,763.65	0.63%
06406RAM9 BANK OF NEW YORK MELLON CORP	2,250,000.00	USD 01/27/2023	CORP	A+	A1	A	AA-	2,328,810.23	1.46%
69371RP42 PACCAR FINANCIAL CORP	2,000,000.00	USD 08/09/2021	CORP	A+	A1	A+	NA	2,059,104.62	1.29%
79766DLQ0 SAN FRANCISCO CALIF CITY & CNTY ARPTS COMMN INTL A	1,000,000.00	USD 05/01/2021	MUNI	A+	A1	A	A+	1,023,485.83	0.64%
857477AV5 STATE STREET CORP	2,000,000.00	USD 05/19/2021	CORP	A+	A1	A	AA-	2,036,187.06	1.27%
89236TCZ6 TOYOTA MOTOR CREDIT CORP	2,000,000.00	USD 04/08/2021	CORP	A+	A1	A+	A+	2,035,008.31	1.27%
9523472D3 WEST CONTRA COSTA CALIF UNI SCH DIST	1,000,000.00	USD 08/01/2023	MUNI	A+	A1	AA-	NA	1,019,505.00	0.64%
--- ---	**11,250,000.00**	**USD 02/10/2022**	---	**A+**	**A1**	**A+**	**AA-**	**11,507,864.71**	**7.20%**

A

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
06051GEE5 BANK OF AMERICA CORP	1,700,000.00	USD 01/05/2021	CORP	A	A2	A-	A+	1,748,668.06	1.09%
14913Q3C1 CATERPILLAR FINANCIAL SERVICES CORP	2,250,000.00	USD 11/18/2022	CORP	A	A3	A	A	2,340,139.15	1.46%
369550BE7 GENERAL DYNAMICS CORP	1,000,000.00	USD 05/11/2021	CORP	A	A2	A	WR	1,028,372.81	0.64%
369550BE7 GENERAL DYNAMICS CORP	500,000.00	USD 05/11/2021	CORP	A	A2	A	WR	514,186.40	0.32%
438516CC8 HONEYWELL INTERNATIONAL INC	1,400,000.00	USD 08/19/2022	CORP	A	A2	A	A	1,403,092.63	0.88%
46625HJE1 JPMORGAN CHASE & CO	2,250,000.00	USD 09/23/2022	CORP	A	A2	A-	AA-	2,379,829.57	1.49%
69353REY0 PNC BANK NA	945,000.00	USD 12/09/2021	CORP	A	A2	A	A+	976,415.28	0.61%
69353REY0 PNC BANK NA	925,000.00	USD 12/09/2021	CORP	A	A2	A	A+	955,750.41	0.60%
76913CAX7 RIVERSIDE CNTY CALIF PENSION OBLIG	500,000.00	USD 02/15/2023	MUNI	A	A2	AA	NA	519,949.69	0.33%
808513AW5 CHARLES SCHWAB CORP	950,000.00	USD 05/21/2021	CORP	A	A2	A	A	976,373.72	0.61%

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--- ---	12,420,000.00	USD 02/21/2022	---	A	A2	A	A+	12,842,777.73	8.04%

A-

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
05531FBG7 TRUIST FINANCIAL CORP	2,000,000.00	USD 06/20/2022	CORP	A-	A3	A-	A	2,101,442.11	1.32%
31677QBS7 FIFTH THIRD BANK NA (OHIO)	2,000,000.00	USD 01/30/2023	CORP	A-	A3	A-	A-	2,061,491.54	1.29%
44644AAD9 HUNTINGTON NATIONAL BANK	1,000,000.00	USD 05/14/2021	CORP	A-	A3	A-	A-	1,028,142.97	0.64%
44644AAH0 HUNTINGTON NATIONAL BANK	1,000,000.00	USD 04/01/2022	CORP	A-	A3	A-	A-	1,054,056.77	0.66%
46124HAA4 INTUIT INC	1,380,000.00	USD 07/15/2023	CORP	A-	A3	A-	NA	1,388,598.93	0.87%
--- ---	7,380,000.00	USD 08/25/2022	CORP	A-	A3	A-	A-	7,633,732.32	4.78%

Summary

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
--- ---	155,416,843.43	USD 08/20/2022	---	AA	Aa2	AA	AA+	159,798,286.56	100.00%

* Grouped by: Rating. * Groups Sorted by: Rating. * Weighted by: Base Market Value + Accrued.

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MetLife Investment Management

Reporting Account Name	Security ID	Security Description 1	Security Description 2	Sector	Shares/Par	Base Cost	Accrued Interest	Base Market Value	Base Unrealized Gain	Base Unrealized Loss	Percent of Asset	Moody's Rating	S&P Rating	Fitch Rating
CALOPTIMA S1-5	GL-110000	CASH			0.0000	2,355,781.13	0.00	2,355,781.13	0.00	0.00	0.00			
CALOPTIMA S1-5	GL-220010	PAYABLE FOR INVESTMENTS PURCHASED			0.0000	-1,876,249.90	0.00	-1,876,249.90	0.00	0.00	0.00			
CALOPTIMA S1-5	17305EFM2	CITIBANK CREDIT CARD ISS A1 A1	2.880% 01/23/2023 DD 01/24/14	Asset Backed	565,000.0000	564,422.07	3,164.00	569,586.44	5,164.37	0.00	0.54	Aaa	NR	AAA
CALOPTIMA S1-5	26208RAD7	DRIVE AUTO RECEIVABLES TR 2 A3	3.040% 03/15/2023 DD 03/20/19	Asset Backed	70,561.0900	70,556.86	95.34	70,709.72	152.86	0.00	0.07	Aaa	AAA	NR
CALOPTIMA S1-5	26208RAE5	DRIVE AUTO RECEIVABLES TRU 2 B	3.170% 11/15/2023 DD 03/20/19	Asset Backed	450,000.0000	449,975.92	634.00	455,866.25	5,890.33	0.00	0.43	Aaa	AAA	NR
CALOPTIMA S1-5	477870AB5	JOHN DEERE OWNER TRUST 20 B A2	2.280% 05/16/2022 DD 07/24/19	Asset Backed	195,254.7900	195,254.14	197.86	196,202.69	948.55	0.00	0.18	Aaa	NR	AAA
CALOPTIMA S1-5	65479PAB5	NISSAN AUTO LEASE TRUST 2 A A2	2.710% 07/15/2021 DD 04/15/19	Asset Backed	155,391.1500	155,389.66	187.16	155,640.20	250.54	0.00	0.15	Aaa	AAA	NR
CALOPTIMA S1-5	98162VAF6	WORLD OMNI AUTO RECEIVABLE B B	2.860% 06/16/2025 DD 05/15/19	Asset Backed	1,030,000	1074619.92	1391.07	1074279.29	0	-340.63	1.01	NR	AA	AA
CALOPTIMA S1-5	3137B1BS0	FHLMC MULTICLASS MTG K026 A2	2.510% 11/25/2022 DD 05/01/13	CMBS	2,005,000.0000	2,017,975.79	4,193.79	2,078,863.80	60,888.01	0.00	1.95	Agency	AA+	AAA
CALOPTIMA S1-5	3137BKRH5	FHLMC MULTICLASS MTG K047 A1	2.827% 12/25/2024 DD 07/01/15	CMBS	168,691.2170	171,771.61	397.41	176,524.19	4,752.58	0.00	0.17	Agency	AA+	AAA
CALOPTIMA S1-5	31381Q6B7	FNMA POOL #0468066	4.295% 06/01/2021 DD 06/01/11	CMBS	1,109,313.9300	1,125,360.97	3,970.42	1,128,077.61	2,716.64	0.00	1.06	Agency	AA+	Agency
CALOPTIMA S1-5	31381R5T7	FNMA POOL #0468958	3.770% 09/01/2021 DD 09/01/11	CMBS	1,190,000.0000	1,197,731.04	3,738.58	1,217,175.97	19,444.93	0.00	1.14	Agency	AA+	Agency
CALOPTIMA S1-5	3138EJRP5	FNMA POOL #0AL2293	VAR RT 06/01/2021 DD 08/01/12	CMBS	226,632.2490	235,924.21	827.20	228,437.66	0.00	-7,486.55	0.21	Agency	AA+	Agency
CALOPTIMA S1-5	3138EJRP5	FNMA POOL #0AL2293	VAR RT 06/01/2021 DD 08/01/12	CMBS	15,265.3840	15,850.87	55.72	15,386.99	0.00	-463.88	0.01	Agency	AA+	Agency
CALOPTIMA S1-5	3138EJRP5	FNMA POOL #0AL2293	VAR RT 06/01/2021 DD 08/01/12	CMBS	23,485.2060	23,665.87	85.72	23,672.30	6.43	0.00	0.02	Agency	AA+	Agency
CALOPTIMA S1-5	3138EJRP5	FNMA POOL #0AL2293	VAR RT 06/01/2021 DD 08/01/12	CMBS	57,538.7550	57,981.45	210.02	57,997.12	15.67	0.00	0.05	Agency	AA+	Agency
CALOPTIMA S1-5	3138EK7G4	FNMA POOL #0AL3594	VAR RT 04/01/2023 DD 05/01/13	CMBS	383,630.6040	390,970.10	862.53	400,885.73	9,915.63	0.00	0.38	Agency	AA+	Agency
CALOPTIMA S1-5	3138EKXL4	FNMA POOL #0AL3382	VAR RT 03/01/2023 DD 03/01/13	CMBS	196,081.6330	197,600.24	379.91	201,740.26	4,140.02	0.00	0.19	Agency	AA+	Agency
CALOPTIMA S1-5	3138L0MH1	FNMA POOL #0AM0359	2.310% 08/01/2022 DD 08/01/12	CMBS	709,461.6530	713,989.61	1,365.71	726,418.93	12,429.32	0.00	0.68	Agency	AA+	Agency
CALOPTIMA S1-5	3140JAU97	FNMA POOL #0BM6007	VAR RT 05/01/2023 DD 05/01/19	CMBS	396,837.4670	410,755.66	861.14	409,464.33	0.00	-1,291.33	0.38	Agency	AA+	Agency
CALOPTIMA S1-5	025816BR9	AMERICAN EXPRESS CO	3.000% 10/30/2024 DD 10/30/17	Corporates	500,000.0000	524,853.12	6,291.67	542,471.23	17,618.11	0.00	0.51	A3	BBB+	A
CALOPTIMA S1-5	05531FBJ1	TRUIST FINANCIAL CORP	2.200% 03/16/2023 DD 09/16/19	Corporates	790,000.0000	789,588.67	724.17	821,880.86	32,292.19	0.00	0.77	A3	A-	A
CALOPTIMA S1-5	06051GEU9	BANK OF AMERICA CORP	3.300% 01/11/2023 DD 01/11/13	Corporates	370,000.0000	368,819.53	2,713.33	392,750.67	23,931.14	0.00	0.37	A2	A-	A+
CALOPTIMA S1-5	06051GEU9	BANK OF AMERICA CORP	3.300% 01/11/2023 DD 01/11/13	Corporates	1,000,000.0000	1,033,319.76	7,333.34	1,061,488.29	28,168.53	0.00	1.00	A2	A-	A+
CALOPTIMA S1-5	06406RAE7	BANK OF NEW YORK MELLON CORP/T	2.950% 01/29/2023 DD 01/29/18	Corporates	882,000.0000	879,918.76	4,481.05	929,072.53	49,153.77	0.00	0.87	A1	A	AA-
CALOPTIMA S1-5	14913R2D8	CATERPILLAR FINANCIAL SERVICES	0.650% 07/07/2023 DD 07/08/20	Corporates	800,000.0000	799,586.00	1,198.89	803,810.34	4,224.34	0.00	0.76	A3	A	A
CALOPTIMA S1-5	172967LC3	CITIGROUP INC	2.900% 12/08/2021 DD 12/08/16	Corporates	900,000.0000	903,155.18	8,192.50	924,523.28	21,368.10	0.00	0.87	A3	BBB+	A
CALOPTIMA S1-5	172967LC3	CITIGROUP INC	2.900% 12/08/2021 DD 12/08/16	Corporates	710,000.0000	703,672.16	6,462.97	729,346.14	25,673.98	0.00	0.69	A3	BBB+	A
CALOPTIMA S1-5	250847EG1	DTE ELECTRIC CO	3.900% 06/01/2021 DD 05/18/11	Corporates	750,000.0000	755,452.84	9,750.00	760,895.72	5,442.88	0.00	0.72	Aa3	A	A+
CALOPTIMA S1-5	31677QBG3	FIFTH THIRD BANK NA	2.250% 06/14/2021 DD 06/14/16	Corporates	215,000.0000	215,576.73	1,437.81	217,607.45	2,030.72	0.00	0.20	A3	A-	A-
CALOPTIMA S1-5	31677QBG3	FIFTH THIRD BANK NA	2.250% 06/14/2021 DD 06/14/16	Corporates	500,000.0000	501,081.02	3,343.75	506,063.83	4,982.81	0.00	0.48	A3	A-	A-
CALOPTIMA S1-5	38141GGQ1	GOLDMAN SACHS GROUP INC/THE	5.250% 07/27/2021 DD 07/27/11	Corporates	750,000.0000	763,646.40	7,000.00	780,038.78	16,392.38	0.00	0.73	A3	BBB+	A
CALOPTIMA S1-5	38141GWT7	GOLDMAN SACHS GROUP INC/THE	3.200% 02/23/2023 DD 01/23/18	Corporates	1,000,000.0000	1,028,094.08	3,377.78	1,060,301.09	32,207.01	0.00	1.00	A3	BBB+	A
CALOPTIMA S1-5	44644AAB3	HUNTINGTON NATIONAL BANK/THE	2.500% 08/07/2022 DD 08/07/17	Corporates	445,000.0000	437,799.46	1,668.75	461,102.33	23,302.87	0.00	0.43	A3	A-	A-
CALOPTIMA S1-5	458140BP4	INTEL CORP	3.400% 03/25/2025 DD 03/25/20	Corporates	1,000,000.0000	1,097,310.05	566.67	1,120,422.00	23,111.95	0.00	1.05	A1	A+	A+
CALOPTIMA S1-5	4581X0CZ9	INTER-AMERICAN DEVELOPMENT BAN	1.750% 09/14/2022 DD 09/14/17	Corporates	1,000,000.0000	994,664.83	826.39	1,029,615.49	34,950.66	0.00	0.97	Aaa	AAA	AAA
CALOPTIMA S1-5	4581X0CZ9	INTER-AMERICAN DEVELOPMENT BAN	1.750% 09/14/2022 DD 09/14/17	Corporates	1,500,000.0000	1,498,626.29	1,239.58	1,544,423.24	45,796.95	0.00	1.45	Aaa	AAA	AAA
CALOPTIMA S1-5	459058GX5	INTERNATIONAL BANK FOR RECONST	1.875% 06/19/2023 DD 06/19/19	Corporates	750,000.0000	758,337.30	3,984.38	782,722.50	24,385.20	0.00	0.74	Aaa	AAA	NR
CALOPTIMA S1-5	46625HJE1	JPMORGAN CHASE & CO	3.250% 09/23/2022 DD 09/24/12	Corporates	920,000.0000	931,808.18	664.44	972,421.43	40,613.25	0.00	0.91	A2	A-	AA-
CALOPTIMA S1-5	46625HJH4	JPMORGAN CHASE & CO	3.200% 01/25/2023 DD 01/25/13	Corporates	1,000,000.0000	992,709.06	5,866.67	1,062,978.06	70,269.00	0.00	1.00	A2	A-	AA-
CALOPTIMA S1-5	55279HAL4	MANUFACTURERS & TRADERS TRUST	2.500% 05/18/2022 DD 05/18/17	Corporates	900,000.0000	901,776.25	8,312.50	930,563.62	28,787.37	0.00	0.87	A3	A	A
CALOPTIMA S1-5	61746BED4	MORGAN STANLEY	2.625% 11/17/2021 DD 11/17/16	Corporates	715,000.0000	709,034.79	6,986.15	732,860.70	23,825.91	0.00	0.69	A3	BBB+	A
CALOPTIMA S1-5	61747WAF6	MORGAN STANLEY	5.750% 01/25/2021 DD 01/25/11	Corporates	730,000.0000	737,095.30	7,695.42	742,473.91	5,378.61	0.00	0.70	A3	BBB+	A
CALOPTIMA S1-5	65339KBF6	NEXTERA ENERGY CAPITAL HOLDING	2.900% 04/01/2022 DD 04/04/19	Corporates	1,000,000.0000	1,026,976.67	14,500.00	1,035,449.87	8,473.20	0.00	0.97	Baa1	BBB+	A-
CALOPTIMA S1-5	68389XBR5	ORACLE CORP	2.625% 02/15/2023 DD 11/09/17	Corporates	1,000,000.0000	985,894.75	3,354.17	1,044,513.61	58,618.86	0.00	0.98	A3	A	A-
CALOPTIMA S1-5	69353RFT0	PNC BANK NA	VAR RT 02/24/2023 DD 02/25/20	Corporates	750,000.0000	750,000.00	1,343.56	763,548.98	13,548.98	0.00	0.72	A2	A	A+
CALOPTIMA S1-5	74456QBP0	PUBLIC SERVICE ELECTRIC AND GA	1.900% 03/15/2021 DD 03/03/16	Corporates	495,000.0000	490,879.15	418.00	498,130.61	7,251.46	0.00	0.47	Aa3	A	NR
CALOPTIMA S1-5	86787EBA4	TRUIST BANK	VAR RT 10/26/2021 DD 10/26/18	Corporates	390,000.0000	390,000.00	5,919.06	390,786.35	786.35	0.00	0.37	A2	A	A+
CALOPTIMA S1-5	87236YAG3	TD AMERITRADE HOLDING CORP	VAR RT 11/01/2021 DD 11/01/18	Corporates	1,250,000.0000	1,239,475.79	1,442.40	1,254,262.38	14,786.59	0.00	1.18	A2	A	NR
CALOPTIMA S1-5	91159HHZ6	US BANCORP	1.450% 05/12/2025 DD 05/12/20	Corporates	1,000,000.0000	1,001,842.73	5,598.61	1,035,467.56	33,624.83	0.00	0.97	A1	A+	A+
CALOPTIMA S1-5	92343VBR4	VERIZON COMMUNICATIONS INC	5.150% 09/15/2023 DD 09/18/13	Corporates	1,000,000.0000	1,120,721.54	2,288.89	1,133,212.83	12,491.29	0.00	1.07	Baa1	BBB+	A-
CALOPTIMA S1-5	94974BFC9	WELLS FARGO & CO	3.500% 03/08/2022 DD 03/08/12	Corporates	1,000,000.0000	1,023,858.64	2,236.11	1,042,324.78	18,466.14	0.00	0.98	A2	BBB+	A+
CALOPTIMA S1-5	95000U2B8	WELLS FARGO & CO	2.625% 07/22/2022 DD 07/24/17	Corporates	750,000.0000	760,747.09	3,773.44	777,598.53	16,851.44	0.00	0.73	A2	BBB+	A+
CALOPTIMA S1-5	04609QAD1	ASSOCIATION OF AMERICAN MEDICA	2.027% 10/01/2023 DD 01/29/20	Municipals	710,000.0000	710,000.00	7,195.85	716,476.46	6,476.46	0.00	0.67	NR	A+	AA
CALOPTIMA S1-5	072024WX6	BAY AREA CA TOLL AUTH TOLL BRI	2.234% 04/01/2023 DD 09/26/19	Municipals	790,000.0000	795,032.92	8,824.30	819,711.90	24,678.98	0.00	0.77	A1	AA-	AA-
CALOPTIMA S1-5	072722AD3	BAYCARE HEALTH SYSTEM INC	2.695% 11/15/2023 DD 04/16/20	Municipals	655,000.0000	655,000.00	8,090.61	699,675.34	44,675.34	0.00	0.66	Aa2	NR	AA
CALOPTIMA S1-5	13063DLZ9	CALIFORNIA ST	3.000% 04/01/2024 DD 04/04/19	Municipals	680,000.0000	705,788.99	10,200.00	735,664.80	29,875.81	0.00	0.69	Aa2	AA-	AA
CALOPTIMA S1-5	13067WRB0	CALIFORNIA ST DEPT OF WTR RESO	0.560% 12/01/2024 DD 08/06/20	Municipals	555,000.0000	555,000.00	474.83	555,771.45	771.45	0.00	0.52	Aa1	AAA	NR
CALOPTIMA S1-5	190335HF9	COAST CA CMNTY CLG DIST	1.556% 08/01/2021 DD 08/31/16	Municipals	415,000.0000	415,000.00	1,076.23	418,751.60	3,751.60	0.00	0.39	Aa1	AA+	NR
CALOPTIMA S1-5	212204JE2	CONTRA COSTA CA CMNTY CLG DIST	1.774% 08/01/2024 DD 09/12/19	Municipals	410,000.0000	410,000.00	1,212.23	425,559.50	15,559.50	0.00	0.40	Aa1	AA+	NR
CALOPTIMA S1-5	283062DN4	EL DORADO CA IRR DIST REVENUE	1.280% 03/01/2025 DD 06/23/20	Municipals	1,000,000.0000	1,000,000.00	1,066.67	1,018,050.00	18,050.00	0.00	0.96	Aa3	AA-	NR
CALOPTIMA S1-5	419792YQ3	HAWAII ST	0.670% 08/01/2025 DD 08/12/20	Municipals	535,000.0000	535,000.00	487.89	533,646.45	0.00	-1,353.55	0.50	Aa2	AA+	AA+
CALOPTIMA S1-5	50520PAD2	LA VERNE CA PENSN OBLIG	3.216% 06/01/2022 DD 08/15/18	Municipals	1,000,000.0000	997,156.62	10,720.00	1,044,320.00	47,163.38	0.00	0.98	NR	AA+	NR

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MetLife Investment Management

Reporting Account Name	Security ID	Security Description 1	Security Description 2	Sector	Shares/Par	Base Cost	Accrued Interest	Base Market Value	Base Unrealized Gain	Base Unrealized Loss	Percent of Asset	Moody's Rating	S&P Rating	Fitch Rating
CALOPTIMA S1-5	544587Y44	LOS ANGELES CA MUNI IMPT CORPL	0.890% 11/01/2024 DD 08/20/20	Municipals	1,000,000.0000	1,000,000.00	1,013.61	1,007,990.00	7,990.00	0.00	0.95	NR	AA-	NR
CALOPTIMA S1-5	576000XB4	MASSACHUSETTS ST SCH BLDG AUTH	1.963% 10/15/2022 DD 11/20/19	Municipals	480,000.0000	480,000.00	4,344.77	492,811.20	12,811.20	0.00	0.46	Aa3	AA	AA+
CALOPTIMA S1-5	576051VX1	MASSACHUSETTS ST WTR RESOURCES	1.862% 08/01/2024 DD 11/01/19	Municipals	830,000.0000	830,000.00	2,575.77	870,030.90	40,030.90	0.00	0.82	Aa1	AA+	AA+
CALOPTIMA S1-5	605581MY0	MISSISSIPPI ST	0.422% 11/01/2023 DD 08/06/20	Municipals	1,190,000.0000	1,190,000.00	767.22	1,191,832.60	1,832.60	0.00	1.12	Aa2	AA	AA
CALOPTIMA S1-5	63968A2A2	NEBRASKA ST PUBLIC PWR DIST RE	2.216% 01/01/2024 DD 10/29/19	Municipals	295,000.0000	295,000.00	1,634.30	307,118.60	12,118.60	0.00	0.29	A1	A+	A+
CALOPTIMA S1-5	63968A2K0	NEBRASKA ST PUBLIC PWR DIST RE	2.216% 01/01/2024 DD 10/29/19	Municipals	220,000.0000	220,000.00	1,218.80	229,037.60	9,037.60	0.00	0.22	A1	A+	A+
CALOPTIMA S1-5	658289J87	NORTH CAROLINA ST UNIV AT RALE	1.069% 10/01/2024 DD 07/07/20	Municipals	850,000.0000	850,000.00	2,120.18	855,754.50	5,754.50	0.00	0.80	Aa1	AA	NR
CALOPTIMA S1-5	677765GV5	OHLONE CA CMNTY CLG DIST	1.814% 08/01/2024 DD 09/26/19	Municipals	1,000,000.0000	1,000,000.00	3,023.33	1,039,460.00	39,460.00	0.00	0.98	Aa1	AA+	NR
CALOPTIMA S1-5	752147HH4	RANCHO SANTIAGO CA CMNTY CLG D	0.634% 09/01/2024 DD 09/02/20	Municipals	1,000,000.0000	1,000,000.00	510.72	1,001,260.00	1,260.00	0.00	0.94	Aa2	AA	NR
CALOPTIMA S1-5	762326AD8	RHODE ISLAND ST TURNPIKE & BRI	2.232% 12/01/2023 DD 12/10/19	Municipals	680,000.0000	680,000.00	5,059.20	696,272.40	16,272.40	0.00	0.65	NR	A-	A
CALOPTIMA S1-5	76913CAW9	RIVERSIDE CNTY CA PENSN OBLG	2.265% 02/15/2022 DD 05/06/20	Municipals	635,000.0000	635,000.00	1,837.80	648,474.70	13,474.70	0.00	0.61	A2	AA	NR
CALOPTIMA S1-5	784710AB1	SSM HEALTH CARE CORP	3.688% 06/01/2023 DD 05/08/18	Municipals	100,000.0000	100,307.53	1,229.33	108,198.48	7,890.95	0.00	0.10	A1	A+	AA-
CALOPTIMA S1-5	784710AB1	SSM HEALTH CARE CORP	3.688% 06/01/2023 DD 05/08/18	Municipals	500,000.0000	498,133.30	6,146.67	540,992.38	42,859.08	0.00	0.51	A1	A+	AA-
CALOPTIMA S1-5	786073AA4	SACRAMENTO CA TRANSIENT OCCUPA	3.455% 06/01/2021 DD 11/01/18	Municipals	805,000.0000	805,000.00	9,270.92	813,669.85	8,669.85	0.00	0.76	A1	NR	NR
CALOPTIMA S1-5	796720ME7	SAN BERNARDINO CA CMNTY CLG DI	1.883% 08/01/2022 DD 12/12/19	Municipals	735,000.0000	735,000.00	2,306.68	754,881.75	19,881.75	0.00	0.71	Aa1	AA	NR
CALOPTIMA S1-5	796720NQ9	SAN BERNARDINO CA CMNTY CLG DI	0.942% 08/01/2024 DD 07/07/20	Municipals	765,000.0000	765,000.00	1,201.05	774,990.90	9,990.90	0.00	0.73	Aa1	AA	NR
CALOPTIMA S1-5	797272QP9	SAN DIEGO CA CMNTY CLG DIST	2.046% 08/01/2024 DD 10/16/19	Municipals	760,000.0000	760,000.00	2,591.60	798,106.40	38,106.40	0.00	0.75	Aaa	AAA	NR
CALOPTIMA S1-5	797412DM2	SAN DIEGO CNTY CA WTR AUTH	0.743% 05/01/2025 DD 07/22/20	Municipals	1,020,000.0000	1,020,000.00	1,452.57	1,019,490.00	0.00	-510.00	0.96	Aa2	AAA	AA+
CALOPTIMA S1-5	797669ZJ0	SAN FRANCISCO CA BAY AREA RAPI	1.971% 07/01/2024 DD 10/31/19	Municipals	750,000.0000	750,000.00	3,695.63	782,010.00	32,010.00	0.00	0.74	NR	AA+	AA+
CALOPTIMA S1-5	79766DSU4	SAN FRANCISCO CALIF CITY &CNTY	1.977% 05/01/2024 DD 09/10/19	Municipals	510,000.0000	510,000.00	4,201.13	522,877.50	12,877.50	0.00	0.49	A1	A	A+
CALOPTIMA S1-5	798189RE8	SAN JOSE CA EVERGREEN CMNTY CL	3.500% 09/01/2023 DD 06/16/20	Municipals	500,000.0000	538,242.94	5,104.17	542,040.00	3,797.06	0.00	0.51	Aa1	AA+	NR
CALOPTIMA S1-5	835569GR9	SONOMA CNTY CA JNR CLG DIST	2.061% 08/01/2024 DD 11/12/19	Municipals	750,000.0000	750,000.00	2,576.25	786,570.00	36,570.00	0.00	0.74	Aa2	AA	NR
CALOPTIMA S1-5	88278PZA5	TEXAS ST UNIV SYS FING REVENUE	2.103% 03/15/2024 DD 11/21/19	Municipals	490,000.0000	490,000.00	457.99	509,864.60	19,864.60	0.00	0.48	Aa2	NR	AA
CALOPTIMA S1-5	899154AV0	TULARE CNTY CA PENSN OBLG	3.348% 06/01/2023 DD 06/25/18	Municipals	1,000,000.0000	1,000,000.00	11,160.00	1,069,570.00	69,570.00	0.00	1.01	A1	AA-	NR
CALOPTIMA S1-5	914455UC2	UNIV OF MICHIGAN MI	1.004% 04/01/2025 DD 06/16/20	Municipals	695,000.0000	695,000.00	2,035.19	699,246.45	4,246.45	0.00	0.66	Aaa	AAA	NR
CALOPTIMA S1-5	916544ET2	UPPER SANTA CLARA VY CA JT PWR	0.827% 08/01/2024 DD 07/23/20	Municipals	690,000.0000	690,000.00	1,077.86	691,048.80	1,048.80	0.00	0.65	NR	AA	AA-
CALOPTIMA S1-5	9174367M3	UTAH ST HSG CORP SF MTGE REVEN	2.340% 01/01/2024 DD 10/02/19	Municipals	445,000.0000	445,000.00	2,603.25	457,108.45	12,108.45	0.00	0.43	Aa2	NR	NR
CALOPTIMA S1-5	923078CU1	VENTURA CNTY CA PUBLIC FING AU	1.223% 11/01/2024 DD 06/11/20	Municipals	505,000.0000	505,000.00	1,887.16	514,150.60	9,150.60	0.00	0.48	Aa1	AA+	NR
CALOPTIMA S1-5	977100DA1	WISCONSIN ST GEN FUND ANNUAL A	2.183% 05/01/2024 DD 08/16/16	Municipals	760,000	763946.46	6912.83	799406	35459.54	0	0.75	Aa2	AA-	AA
CALOPTIMA S1-5	3134GWGB6	FEDERAL HOME LN MTG CORP	0.450% 07/28/2023 DD 07/28/20	RMBS	800,000.0000	800,000.00	630.00	800,281.06	281.06	0.00	0.75	Agency	AA+	Agency
CALOPTIMA S1-5	3134GWND4	FEDERAL HOME LN MTG CORP	0.600% 08/12/2025 DD 08/12/20	RMBS	1,100,000.0000	1,098,821.85	898.33	1,097,756.84	0.00	-1,065.01	1.03	Agency	AA+	Agency
CALOPTIMA S1-5	3135G0S38	FEDERAL NATL MTG ASSN	2.000% 01/05/2022 DD 01/09/17	RMBS	2,250,000.0000	2,252,167.74	10,750.00	2,303,636.72	51,468.98	0.00	2.17	Agency	AA+	Agency
CALOPTIMA S1-5	3135G0S38	FEDERAL NATL MTG ASSN	2.000% 01/05/2022 DD 01/09/17	RMBS	1,500,000.0000	1,503,706.86	7,166.67	1,535,757.81	32,050.95	0.00	1.44	Agency	AA+	Agency
CALOPTIMA S1-5	3135G0V75	FEDERAL NATL MTG ASSN	1.750% 07/02/2024 DD 07/08/19	RMBS	1,100,000.0000	1,105,597.28	4,759.03	1,160,982.15	55,384.87	0.00	1.09	Agency	AA+	Agency
CALOPTIMA S1-5	3135G0V75	FEDERAL NATL MTG ASSN	1.750% 07/02/2024 DD 07/08/19	RMBS	1,010,000.0000	1,013,804.94	4,369.65	1,065,992.71	52,187.77	0.00	1.00	Agency	AA+	Agency
CALOPTIMA S1-5	3136A5KR6	FNMA GTD REMIC P/T 12-31 AD	1.750% 10/25/2022 DD 03/01/12	RMBS	59,009.9600	58,514.05	86.06	59,105.46	591.41	0.00	0.06	Agency	AA+	Agency
CALOPTIMA S1-5	3136A5KR6	FNMA GTD REMIC P/T 12-31 AD	1.750% 10/25/2022 DD 03/01/12	RMBS	148,718.7420	147,575.91	216.88	148,959.43	1,383.52	0.00	0.14	Agency	AA+	Agency
CALOPTIMA S1-5	3137AXHP1	FHLMC MULTICLASS MTG K024 A2	2.573% 09/25/2022 DD 01/01/13	RMBS	640,000.0000	644,008.72	1,372.26	664,203.14	20,194.42	0.00	0.62	Aaa	AA+	Agency
CALOPTIMA S1-5	3137AXHP1	FHLMC MULTICLASS MTG K024 A2	2.573% 09/25/2022 DD 01/01/13	RMBS	460,000.0000	462,753.96	986.32	477,396.00	14,642.04	0.00	0.45	Aaa	AA+	Agency
CALOPTIMA S1-5	3137B1UG5	FHLMC MULTICLASS MTG K027 A2	2.637% 01/25/2023 DD 05/01/13	RMBS	700,000.0000	700,083.35	1,538.25	729,242.36	29,159.01	0.00	0.69	Agency	AA+	AAA
CALOPTIMA S1-5	3137B1UG5	FHLMC MULTICLASS MTG K027 A2	2.637% 01/25/2023 DD 05/01/13	RMBS	560,000.0000	560,255.95	1,230.60	583,393.89	23,137.94	0.00	0.55	Agency	AA+	AAA
CALOPTIMA S1-5	3137B2ZH6	FHLMC MULTICLASS MTG 4221 HJ	1.500% 07/15/2023 DD 06/01/13	RMBS	82,864.2880	82,042.99	103.58	83,559.08	1,516.09	0.00	0.08	Agency	AA+	Agency
CALOPTIMA S1-5	3137B7MZ9	FHLMC MULTICLASS MTG K036 A2	VAR RT 10/25/2023 DD 02/01/14	RMBS	450,000.0000	489,408.59	1,322.63	488,098.76	0.00	-1,309.83	0.46	Aaa	AA+	AAA
CALOPTIMA S1-5	3137BFE80	FHLMC MULTICLASS MTG K041 A1	2.720% 08/25/2024 DD 12/01/14	RMBS	1,943,149.4120	2,025,065.95	4,404.47	2,023,212.03	0.00	-1,853.92	1.90	Agency	AA+	AAA
CALOPTIMA S1-5	3137EADB2	FEDERAL HOME LN MTG CORP	2.375% 01/13/2022 DD 01/13/12	RMBS	1,500,000.0000	1,510,604.66	7,718.75	1,543,298.66	32,694.00	0.00	1.45	Agency	AA+	Agency
CALOPTIMA S1-5	3137EAEV7	FEDERAL HOME LN MTG CORP	0.250% 08/24/2023 DD 08/21/20	RMBS	1,100,000.0000	1,098,919.41	305.56	1,100,745.92	1,826.51	0.00	1.03	Agency	AA+	Agency
CALOPTIMA S1-5	3137GAUY1	FHLMC MULTICLASS MTG 3737 MA	1.500% 10/15/2022 DD 10/01/10	RMBS	165,819.6040	163,164.29	207.27	166,945.25	3,780.96	0.00	0.16	Agency	AA+	Agency
CALOPTIMA S1-5	9128285H9	U S TREASURY NOTE	VAR RT 10/31/2020 DD 10/31/18	US Government	800,000.0000	800,032.65	206.26	800,018.76	0.00	-13.89	0.75	Govt	AA+	Govt
CALOPTIMA S1-5	9128284H0	US TREAS-CPI INFLAT	0.625%004/15/2023 DD 04/15/18	US Government	1,017,146.3600	1,022,036.06	2,935.41	1,064,268.84	42,232.78	0.00	1.00	Govt	AA+	Govt
CALOPTIMA S1-5	9128284H0	US TREAS-CPI INFLAT	0.625%004/15/2023 DD 04/15/18	US Government	510,760.7400	512,152.68	1,474.02	534,423.32	22,270.64	0.00	0.50	Govt	AA+	Govt
CALOPTIMA S1-5	9128286N5	US TREAS-CPI INFLAT	0.500% 04/15/2024 DD 04/15/19	US Government	1,515,061.0000	1,531,242.39	3,497.88	1,608,667.30	77,424.91	0.00	1.51	Govt	AA+	Govt
CALOPTIMA S1-5	9128286N5	US TREAS-CPI INFLAT	0.500% 04/15/2024 DD 04/15/19	US Government	508,444.2000	515,984.47	1,173.87	539,857.84	23,873.37	0.00	0.51	Govt	AA+	Govt
CALOPTIMA S1-5	912828D56	U S TREASURY NOTE	2.375% 08/15/2024 DD 08/15/14	US Government	1,055,000.0000	1,089,268.53	3,200.13	1,143,397.46	54,128.93	0.00	1.07	Govt	AA+	Govt
CALOPTIMA S1-5	912828D56	U S TREASURY NOTE	2.375% 08/15/2024 DD 08/15/14	US Government	1,470,000.0000	1,514,621.31	4,458.93	1,593,169.92	78,548.61	0.00	1.50	Govt	AA+	Govt
CALOPTIMA S1-5	912828D56	U S TREASURY NOTE	2.375% 08/15/2024 DD 08/15/14	US Government	640,000.0000	656,933.76	1,941.30	693,625.00	36,691.24	0.00	0.65	Govt	AA+	Govt
CALOPTIMA S1-5	912828D56	U S TREASURY NOTE	2.375% 08/15/2024 DD 08/15/14	US Government	1,475,000.0000	1,512,865.05	4,474.10	1,598,588.86	85,723.81	0.00	1.50	Govt	AA+	Govt
CALOPTIMA S1-5	912828G38	U S TREASURY NOTE	2.250% 11/15/2024 DD 11/15/14	US Government	750,000.0000	767,790.50	6,373.98	812,285.16	44,494.66	0.00	0.76	Govt	AA+	Govt
CALOPTIMA S1-5	912828G38	U S TREASURY NOTE	2.250% 11/15/2024 DD 11/15/14	US Government	495,000.0000	506,722.81	4,206.83	536,108.21	29,385.40	0.00	0.50	Govt	AA+	Govt
CALOPTIMA S1-5	912828G38	U S TREASURY NOTE	2.250% 11/15/2024 DD 11/15/14	US Government	995,000.0000	1,015,077.76	8,456.15	1,077,631.65	62,553.89	0.00	1.01	Govt	AA+	Govt
CALOPTIMA S1-5	912828G38	U S TREASURY NOTE	2.250% 11/15/2024 DD 11/15/14	US Government	950,000.0000	983,339.61	8,073.71	1,028,894.53	45,554.92	0.00	0.97	Govt	AA+	Govt
CALOPTIMA S1-5	912828L57	U S TREASURY NOTE	1.750% 09/30/2022 DD 09/30/15	US Government	150,000.0000	147,433.42	7.21	154,851.56	7,418.14	0.00	0.15	Govt	AA+	Govt
CALOPTIMA S1-5	912828T26	U S TREASURY NOTE	1.375% 09/30/2023 DD 09/30/16	US Government	1,035,000.0000	1,027,553.28	39.10	1,072,761.33	45,208.05	0.00	1.01	Govt	AA+	Govt
CALOPTIMA S1-5	912828T26	U S TREASURY NOTE	1.375% 09/30/2023 DD 09/30/16	US Government	1,200,000.0000	1,198,639.55	45.33	1,243,781.26	45,141.71	0.00	1.17	Govt	AA+	Govt

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MetLife Investment Management

Reporting Account Name	Security ID	Security Description 1	Security Description 2	Sector	Shares/Par	Base Cost	Accrued Interest	Base Market Value	Base Unrealized Gain	Base Unrealized Loss	Percent of Asset	Moody's Rating	S&P Rating	Fitch Rating
CALOPTIMA S1-5	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	820,000.0000	815,385.33	5,206.22	840,788.28	25,402.95	0.00	0.79	Govt	AA+	Govt
CALOPTIMA S1-5	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	1,030,000.0000	1,024,851.92	6,539.51	1,056,112.11	31,260.19	0.00	0.99	Govt	AA+	Govt
CALOPTIMA S1-5	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	515,000.0000	512,426.43	3,269.76	528,056.05	15,629.62	0.00	0.50	Govt	AA+	Govt
CALOPTIMA S1-5	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	770,000.0000	766,150.62	4,888.76	789,520.70	23,370.08	0.00	0.74	Govt	AA+	Govt
CALOPTIMA S1-5	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	1,800,000.0000	1,791,464.64	11,428.28	1,845,632.81	54,168.17	0.00	1.74	Govt	AA+	Govt
CALOPTIMA S1-5	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	925,000.0000	920,510.06	5,872.87	948,450.19	27,940.13	0.00	0.89	Govt	AA+	Govt
CALOPTIMA S1-5	912828YK0	U S TREASURY NOTE	1.375% 10/15/2022 DD 10/15/19	US Government	1,030,000.0000	1,023,824.41	6,539.51	1,056,112.11	32,287.70	0.00	0.99	Govt	AA+	Govt
CALOPTIMA S1-5	912828ZL7	U S TREASURY NOTE	0.375% 04/30/2025 DD 04/30/20	US Government	2,125,000.0000	2,114,735.27	3,334.75	2,137,534.19	22,798.92	0.00	2.01	Govt	AA+	Govt
CALOPTIMA S1-5	91282CAJ0	U S TREASURY NOTE	0.250% 08/31/2025 DD 08/31/20	US Government	1,075,000.0000	1,073,712.54	230.15	1,074,160.16	447.62	0.00	1.01	Govt	AA+	Govt

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Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
Cash							
	CASH OR STIF	USD	6,105,361.73	6,105,361.73	0.00	1.000	1.56%
Total for Cash			**6,105,361.73**	**6,105,361.73**	**0.00**		**1.56%**
Money Markets							
2,000,000.000	BAYERISCHE LANDESBANK YCD Mat: 10/1/20 Cpn: 0.38% Moody's: P-1 S&P: Fitch: F1 Tr Date: 7/9/20 St Date: 7/14/20	0727MCAC1	2,000,481.96 886.67	2,000,014.42 2,554.44	(467.54)	100.001	0.51%
30,000,000.000	U.S. TREASURY BILL Mat: 10/1/20 Cpn: 0.00% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 7/1/20 St Date: 7/1/20	9127962J7	29,996,186.94 0.00	29,996,239.88 3,813.06	52.94	100.000	7.65%
1,460,000.000	BNP PARIBAS YCD FRN Mat: 10/9/20 Cpn: 0.47% Moody's: S&P: Fitch: Tr Date: 7/7/20 St Date: 7/8/20	05586FGP6	1,460,611.26 5,547.56	1,460,127.09 1,595.61	(484.17)	100.009	0.37%
1,550,000.000	SKANDINAV ENSKILDA BK YCD FRN Mat: 10/16/20 Cpn: 0.44% Moody's: S&P: Fitch: Tr Date: 2/19/20 St Date: 2/20/20	83050PEX3	1,551,963.85 3,032.92	1,550,217.29 1,461.64	(1,746.56)	100.014	0.40%
25,000,000.000	U.S. TREASURY BILL Mat: 10/22/20 Cpn: 0.00% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 7/21/20 St Date: 7/21/20	9127962S7	24,992,798.96 0.00	24,993,336.74 5,575.00	537.78	99.995	6.38%
50,000,000.000	U.S. TREASURY BILL Mat: 11/10/20 Cpn: 0.00% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 9/15/20 St Date: 9/16/20	9127964R7	49,992,743.06 0.00	49,994,035.70 1,979.17	1,292.64	99.992	12.75%
2,000,000.000	BANK OF NOVA SCOTIA YCD FRN Mat: 11/13/20 Cpn: 0.38% Moody's: P-1 S&P: A-1 Fitch: F1+ Tr Date: 11/14/19 St Date: 11/15/19	06417MEQ4	2,000,000.00 0.00	2,000,637.50 1,043.97	637.50	100.032	0.51%
25,000,000.000	U.S. TREASURY BILL Mat: 11/19/20 Cpn: 0.00% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 7/21/20 St Date: 7/21/20	9127963A5	24,990,378.82 0.00	24,991,392.71 5,725.00	1,013.89	99.988	6.38%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
2,000,000.000	WESTPAC BANK FRN YCD Mat: 12/11/20 Cpn: 0.40% Moody's: P-1 S&P: A-1+ Fitch: F1 Tr Date: 12/11/19 St Date: 12/12/19	96130AES3	2,000,000.00 0.00	2,000,944.54 444.72	944.54	100.047	0.51%
5,000,000.000	U.S. TREASURY BILL Mat: 1/7/21 Cpn: 0.00% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 9/30/20 St Date: 9/30/20	9127963T4	4,998,755.63 0.00	4,998,730.88 12.57	(24.76)	99.975	1.27%
25,000,000.000	U.S. TREASURY BILL Mat: 1/21/21 Cpn: 0.00% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 7/21/20 St Date: 7/23/20	9127963V9	24,983,885.42 0.00	24,986,263.13 6,197.92	2,377.71	99.970	6.37%
2,000,000.000	BAYERISCHE LANDESBANK FRN YCD Mat: 1/22/21 Cpn: 0.46% Moody's: S&P: Fitch: Tr Date: 1/28/20 St Date: 1/29/20	0727MAX30	2,000,414.76 444.53	1,996,720.08 1,805.57	(3,694.68)	99.836	0.51%
1,500,000.000	CREDIT SUISSE NY YCD Mat: 1/22/21 Cpn: 1.80% Moody's: P-1 S&P: A-1 Fitch: F1 Tr Date: 1/23/20 St Date: 1/24/20	22549LZD0	1,500,000.00 0.00	1,507,728.24 18,825.00	7,728.24	100.515	0.39%
1,000,000.000	MIZUHO BANK YCD Mat: 1/22/21 Cpn: 1.73% Moody's: P-1 S&P: A-1 Fitch: F1 Tr Date: 1/24/20 St Date: 1/24/20	60710AJP8	1,000,000.00 0.00	1,004,930.87 12,061.94	4,930.87	100.493	0.26%
2,000,000.000	NATIXIS NY YCD Mat: 1/22/21 Cpn: 1.77% Moody's: P-1 S&P: A-1 Fitch: F1 Tr Date: 1/24/20 St Date: 1/24/20	63873QDQ4	2,000,000.00 0.00	2,010,114.64 24,681.67	10,114.64	100.506	0.52%
1,970,000.000	BANCO SANTANDER YCD Mat: 1/25/21 Cpn: 1.83% Moody's: P-1 S&P: A-1 Fitch: F1 Tr Date: 1/24/20 St Date: 1/27/20	05966DXF4	1,970,000.00 0.00	1,980,608.61 24,835.13	10,608.61	100.539	0.51%
2,000,000.000	CREDIT AGRICOLE YCD Mat: 1/25/21 Cpn: 1.76% Moody's: P-1 S&P: A-1 Fitch: F1 Tr Date: 1/24/20 St Date: 1/27/20	22535CKZ3	2,000,000.00 0.00	2,010,315.94 24,248.89	10,315.94	100.516	0.52%
1,000,000.000	MIZUHO BANK LTD FRN YCD Mat: 3/11/21 Cpn: 0.31% Moody's: S&P: Fitch: Tr Date: 9/2/20 St Date: 9/3/20	60710ARE4	1,000,118.00 206.60	1,000,277.51 172.92	159.51	100.028	0.26%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
25,000,000.000	U.S. TREASURY BILL	9127962Q1	24,974,696.18	24,979,172.85	4,476.67	99.943	6.37%
	Mat: 4/22/21 Cpn: 0.00%		0.00	6,625.00			
	Moody's: Aaa S&P: AA+u Fitch: AAA						
	Tr Date: 7/21/20 St Date: 7/21/20						
12,000,000.000	U.S. TREASURY BILL	9127964L0	11,986,756.00	11,986,985.33	229.33	99.892	3.06%
	Mat: 9/9/21 Cpn: 0.00%		0.00	38.50			
	Moody's: Aaa S&P: AA+u Fitch: AAA						
	Tr Date: 9/30/20 St Date: 9/30/20						
Total for Money Markets			**217,399,790.84**	**217,448,793.94**	**49,003.10**		**55.50%**
			10,118.28	**143,697.72**			
Government Related							
5,000,000.000	INTER-AMERICAN DEVELOPMENT BANK FRN	45818WBT2	5,000,090.00	5,000,027.40	(62.60)	100.001	1.28%
	Mat: 10/9/20 Cpn: 0.16%		354.86	475.54			
	Moody's: Aaa S&P: AAA Fitch: AAA						
	Tr Date: 7/21/20 St Date: 7/23/20						
1,000,000.000	INTER-AMERICAN DEVELOPMENT BANK	4581X0CS5	1,007,900.00	1,007,492.50	(407.50)	100.749	0.26%
	Mat: 3/15/21 Cpn: 1.88%		520.83	833.33			
	Moody's: Aaa S&P: AAA Fitch: AAA						
	Tr Date: 9/23/20 St Date: 9/25/20						
3,000,000.000	INTL BANK RECON & DEVELOP	459058FH1	3,028,980.00	3,022,742.31	(6,237.69)	100.758	0.77%
	Mat: 5/24/21 Cpn: 1.38%		7,338.67	14,552.08			
	Moody's: Aaa S&P: AAA Fitch: AAAu						
	Tr Date: 7/22/20 St Date: 7/28/20						
1,000,000.000	INTER-AMERICAN DEVELOPMENT BANK FRN	45818WCP9	1,001,210.00	1,000,696.94	(513.06)	100.070	0.26%
	Mat: 9/16/22 Cpn: 0.35%		19.44	146.83			
	Moody's: Aaa S&P: AAA Fitch:						
	Tr Date: 9/16/20 St Date: 9/18/20						
Total for Government Related			**10,038,180.00**	**10,030,959.15**	**(7,220.85)**		**2.56%**
			8,233.80	**16,007.79**			
Agencies							
10,000,000.000	FHLB 1ML+7 FRN	3130AHH97	10,004,185.30	10,004,551.80	366.50	100.046	2.55%
	Mat: 2/1/21 Cpn: 0.23%		1,957.50	1,875.00			
	Moody's: Aaa S&P: AA+ Fitch: AAA						
	Tr Date: 6/30/20 St Date: 6/30/20						
5,000,000.000	FHLB FRN	3130AJVE6	5,000,000.00	5,001,221.75	1,221.75	100.024	1.28%
	Mat: 5/24/21 Cpn: 0.14%		0.00	137.08			
	Moody's: Aaa S&P: AA+u Fitch: AAA						
	Tr Date: 7/21/20 St Date: 7/24/20						

Portfolio Positions

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Currency: USD

Units	Security			Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
3,000,000.000	FFCB FRN			3133EJZP7	3,000,736.98	3,000,728.79	(8.19)	100.024	0.77%
	Mat: 9/17/21	Cpn: 0.17%			83.70	198.92			
	Moody's: Aaa	S&P: AA+	Fitch: AAA						
	Tr Date: 7/21/20	St Date: 7/22/20							
10,000,000.000	FFCB FRN			3133ELW42	10,000,240.90	10,006,228.70	5,987.80	100.062	2.55%
	Mat: 10/20/21	Cpn: 0.17%			491.88	507.99			
	Moody's: Aaa	S&P: AA+	Fitch: AAA						
	Tr Date: 7/28/20	St Date: 7/29/20							
3,000,000.000	FFCB 1ML+13 FRN			3133EK5T9	3,006,024.00	3,004,874.97	(1,149.03)	100.163	0.77%
	Mat: 11/5/21	Cpn: 0.29%			108.35	625.37			
	Moody's: Aaa	S&P: AA+	Fitch: AAA						
	Tr Date: 5/4/20	St Date: 5/8/20							
10,000,000.000	FHLMC FRN SOFR+15			3134GVFL7	9,998,295.30	10,011,321.20	13,025.90	100.113	2.55%
	Mat: 3/4/22	Cpn: 0.22%			1,658.33	1,772.22			
	Moody's: Aaa	S&P: AA+u	Fitch: AAA						
	Tr Date: 6/30/20	St Date: 6/30/20							
Total for Agencies					**41,009,482.48**	**41,028,927.21**	**19,444.73**		**10.47%**
					4,299.76	**5,116.57**			
Tax-Exempt									
1,320,000.000	CA LOS ANGELES CITY TRANS			544351PK9	1,366,120.80	1,356,742.21	(9,378.59)	102.784	0.35%
	Mat: 6/24/21	Cpn: 4.00%			0.00	11,440.00			
	Moody's: MIG1	S&P: SP-1+	Fitch:						
	Tr Date: 7/8/20	St Date: 7/13/20							
2,000,000.000	CA LOS ANGELES COUNTY TRANS			544657HX0	2,072,120.00	2,056,719.98	(15,400.02)	102.836	0.53%
	Mat: 6/30/21	Cpn: 4.00%			0.00	18,000.00			
	Moody's: MIG1	S&P: SP-1+	Fitch: F1+						
	Tr Date: 7/1/20	St Date: 7/10/20							
Total for Tax-Exempt					**3,438,240.80**	**3,413,462.19**	**(24,778.61)**		**0.88%**
					0.00	**29,440.00**			
Taxable Muni									
2,000,000.000	CA LOS ANGELES MTA CP TXB			54531HBM8	2,000,000.00	2,000,000.00	0.00	100.000	0.51%
	Mat: 10/1/20	Cpn: 0.18%			0.00	501.64			
	Moody's: P-1	S&P: A-1	Fitch:						
	Tr Date: 8/11/20	St Date: 8/11/20							
765,000.000	CA PALM DESERT REDEV AGY TAB TXB			696624AT2	767,669.85	765,015.70	(2,654.15)	100.002	0.20%
	Mat: 10/1/20	Cpn: 2.25%			3,633.75	8,606.25			
	Moody's:	S&P: AA	Fitch:						
	Tr Date: 12/13/19	St Date: 12/17/19							

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
1,500,000.000	CA SAN BERNARDINO CNTY COPS TXBL Mat: 10/1/20 Cpn: 2.00% Moody's: Aa2 S&P: AA Fitch: Tr Date: 11/13/19 St Date: 11/15/19	796815ZE1	1,502,445.00 3,666.67	1,500,060.77 15,000.00	(2,384.24)	100.004	0.39%
1,950,000.000	CA SAN FRANCISCO USD GO/ULT TXB Mat: 10/1/20 Cpn: 0.18% Moody's: Aa2 S&P: AA Fitch: Tr Date: 8/21/20 St Date: 8/27/20	79771TNS2	1,950,000.00 0.00	1,949,981.55 331.50	(18.45)	99.999	0.50%
575,000.000	CA SAN FRAN PUB UTIL WATER-GREEN TXB Mat: 11/1/20 Cpn: 1.81% Moody's: Aa2 S&P: AA- Fitch: Tr Date: 12/13/19 St Date: 1/9/20	79765R4K2	575,000.00 0.00	575,717.35 7,591.09	717.35	100.125	0.15%
360,000.000	BAYLOR SCOTT & WHITE TAXABLE Mat: 11/15/20 Cpn: 2.12% Moody's: Aa3 S&P: AA- Fitch: Tr Date: 8/21/19 St Date: 8/23/19	072863AA1	360,079.20 2,080.54	360,190.44 2,887.28	111.24	100.053	0.09%
2,000,000.000	CA STATE GO/ULT CP TXB Mat: 12/8/20 Cpn: 0.19% Moody's: P-1 S&P: A-1+ Fitch: F1 Tr Date: 9/14/20 St Date: 9/14/20	13068PED4	2,000,000.00 0.00	2,000,000.00 176.50	0.00	100.000	0.51%
1,400,000.000	CA STATE GO/ULT CP TXB Mat: 12/23/20 Cpn: 0.50% Moody's: P-1 S&P: A-1+ Fitch: F1+ Tr Date: 9/29/20 St Date: 9/29/20	13068BGG6	1,400,000.00 0.00	1,400,000.00 38.25	0.00	100.000	0.36%
2,000,000.000	CA SAN DIEGO USD GO/ULT TXB Mat: 1/1/21 Cpn: 0.23% Moody's: Aa2 S&P: Fitch: F1+ Tr Date: 8/14/20 St Date: 8/27/20	797356BD3	2,000,000.00 0.00	2,000,262.00 434.44	262.00	100.013	0.51%
510,000.000	CA RIVERSIDE CNTY PENSN OBLG TXB Mat: 2/15/21 Cpn: 2.17% Moody's: A2 S&P: AA Fitch: Tr Date: 4/23/20 St Date: 5/6/20	76913CAV1	510,000.00 0.00	512,481.48 1,410.86	2,481.48	100.487	0.13%
2,508,441.179	CA DEPT WTR RESOURCES-PWR SUPPLY TXB Mat: 5/1/21 Cpn: 1.71% Moody's: WR S&P: AA+ Fitch: WD Tr Date: 6/18/19 St Date: 6/20/19	13066YTY5	2,503,755.87 10,303.10	2,529,930.34 17,904.00	26,174.48	100.857	0.65%
1,000,000.000	CA UNIVERSITY OF CALIFORNIA TXB Mat: 5/15/21 Cpn: 1.79% Moody's: Aa2 S&P: AA Fitch: AA Tr Date: 2/27/20 St Date: 3/2/20	91412GD51	1,004,870.00 5,320.28	1,008,685.00 6,762.22	3,815.00	100.869	0.26%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
1,720,000.000	CA UNIVERSITY OF CALIFORNIA TXB Mat: 5/15/21 Cpn: 0.33% Moody's: Aa2 S&P: AA Fitch: AA Tr Date: 7/10/20 St Date: 7/16/20	91412HFH1	1,720,000.00 0.00	1,720,437.50 1,182.50	437.50	100.025	0.44%
1,200,000.000	CA BEVERLY HILLS PFA LEASE REV TXB Mat: 6/1/21 Cpn: 0.26% Moody's: S&P: AA+ Fitch: Tr Date: 9/23/20 St Date: 10/15/20	088006JV4	1,200,000.00 0.00	1,199,861.94 0.00	(138.06)	99.989	0.31%
1,900,000.000	CA HEALTH FACS-NO PLACE LIKE HOME-TXB Mat: 6/1/21 Cpn: 1.90% Moody's: Aa3 S&P: AA- Fitch: AA- Tr Date: 11/20/19 St Date: 11/25/19	13032UUY2	1,900,000.00 0.00	1,917,259.05 12,008.00	17,259.05	100.908	0.49%
610,000.000	CA SAN BERNARDINO CCD TXB Mat: 8/1/21 Cpn: 1.82% Moody's: Aa1 S&P: AA Fitch: Tr Date: 11/21/19 St Date: 12/12/19	796720MD9	610,000.00 0.00	617,531.74 1,854.40	7,531.74	101.235	0.16%
1,400,000.000	CA UPPER SANTA CLARA VLY JPA REV TXB Mat: 8/1/21 Cpn: 0.42% Moody's: S&P: AA Fitch: AA- Tr Date: 7/16/20 St Date: 7/23/20	916544EQ8	1,400,000.00 0.00	1,401,297.97 1,097.44	1,297.97	100.093	0.36%
1,000,000.000	CA ANAHEIM HSG & PUB IMPT AUTH TXB Mat: 10/1/21 Cpn: 1.65% Moody's: S&P: AA- Fitch: AA- Tr Date: 2/7/20 St Date: 3/4/20	032556GM8	1,000,000.00 0.00	1,010,990.52 9,470.25	10,990.52	101.099	0.26%
520,000.000	CA LOS ANGELES MUNI IMPT CORP LEASE TXB Mat: 11/1/21 Cpn: 0.42% Moody's: S&P: AA- Fitch: Tr Date: 8/14/20 St Date: 8/20/20	544587X94	520,000.00 0.00	520,731.93 245.77	731.93	100.141	0.13%
1,020,000.000	MI STATE GO/ULT TXB Mat: 11/1/21 Cpn: 1.78% Moody's: Aa1 S&P: AA Fitch: AA Tr Date: 9/28/20 St Date: 9/30/20	594612CX9	1,037,013.60 7,510.35	1,036,671.96 7,560.75	(341.64)	101.635	0.27%
Total for Taxable Muni			**25,960,833.52** **32,514.69**	**26,027,107.23** **95,063.15**	**66,273.71**		**6.66%**
Credit							
750,000.000	PACCAR FINANCIAL Mat: 11/13/20 Cpn: 2.05% Moody's: A1 S&P: A+ Fitch: Tr Date: 3/10/20 St Date: 3/12/20	69371RN85	753,862.50 5,082.29	751,458.75 5,893.75	(2,403.75)	100.195	0.19%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
1,000,000.000	MORGAN STANLEY Mat: 1/25/21 Cpn: 5.75% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 10/24/19 St Date: 10/28/19	61747WAF6	1,045,110.00 14,854.17	1,017,000.00 10,541.67	(28,110.00)	101.700	0.26%
645,000.000	TRUIST FIN CORP FRN Mat: 2/1/21 Cpn: 0.47% Moody's: A3 S&P: A- Fitch: A Tr Date: 10/23/17 St Date: 10/26/17	05531FBA0	645,000.00 0.00	645,255.79 497.89	255.79	100.040	0.16%
1,235,000.000	US BANK CINCINNATI FRN Mat: 4/26/21 Cpn: 0.56% Moody's: A1 S&P: AA- Fitch: AA- Tr Date: 4/24/18 St Date: 4/26/18	90331HNQ2	1,235,000.00 0.00	1,236,549.93 1,278.12	1,549.93	100.126	0.32%
1,000,000.000	AMERICAN EXPRESS Mat: 5/5/21 Cpn: 2.25% Moody's: A2 S&P: A- Fitch: A Tr Date: 2/28/20 St Date: 3/3/20	0258M0EB1	1,009,080.00 7,375.00	1,010,110.00 9,125.00	1,030.00	101.011	0.26%
810,000.000	APPLE Mat: 5/6/21 Cpn: 2.85% Moody's: Aa1 S&P: AA+ Fitch: Tr Date: 3/6/20 St Date: 3/10/20	037833AR1	826,775.10 7,951.50	822,668.40 9,298.13	(4,106.70)	101.564	0.21%
1,000,000.000	TRUIST FIN CORP Mat: 5/10/21 Cpn: 2.05% Moody's: A3 S&P: A- Fitch: A Tr Date: 10/24/19 St Date: 10/28/19	05531FAV5	1,001,440.00 9,566.67	1,009,285.00 8,029.17	7,845.00	100.929	0.26%
1,000,000.000	CITIZENS BANK Mat: 5/13/21 Cpn: 2.55% Moody's: Baa1 S&P: A- Fitch: BBB+ Tr Date: 11/1/19 St Date: 11/5/19	17401QAE1	1,007,940.00 12,183.33	1,011,835.00 9,775.00	3,895.00	101.184	0.26%
1,250,000.000	HUNTINGTON NATL BANK Mat: 5/14/21 Cpn: 3.25% Moody's: A3 S&P: A- Fitch: A- Tr Date: 10/24/19 St Date: 10/28/19	44644AAD9	1,273,607.50 19,138.89	1,268,487.50 15,460.07	(5,120.00)	101.479	0.33%
850,000.000	AMERICAN EXPRESS FRN Mat: 5/17/21 Cpn: 0.81% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 5/14/18 St Date: 5/17/18	025816BV0	850,000.00 0.00	852,164.95 855.45	2,164.95	100.255	0.22%
635,000.000	CITIGROUP Mat: 7/23/21 Cpn: 3.40% Moody's: Aa3 S&P: A+ Fitch: A+ Tr Date: 10/24/19 St Date: 10/28/19	17325FAQ1	650,119.35 5,697.36	649,951.08 4,078.11	(168.28)	102.355	0.17%

Portfolio Positions

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Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
500,000.000	FIFTH THIRD BANK	31677QBN8	513,725.00	511,300.00	(2,425.00)	102.260	0.13%
	Mat: 7/26/21 Cpn: 3.35%		372.22	3,024.31			
	Moody's: A3 S&P: A- Fitch: A-						
	Tr Date: 7/31/20 St Date: 8/4/20						
1,000,000.000	APPLE	037833CC2	1,004,176.20	1,010,095.00	5,918.80	101.010	0.26%
	Mat: 8/4/21 Cpn: 1.55%		1,248.61	2,454.17			
	Moody's: Aa1 S&P: AA+ Fitch:						
	Tr Date: 2/28/20 St Date: 3/3/20						
1,000,000.000	MICROSOFT	594918BP8	1,004,540.00	1,010,455.00	5,915.00	101.046	0.26%
	Mat: 8/8/21 Cpn: 1.55%		1,076.39	2,281.94			
	Moody's: Aaa S&P: AAA Fitch: AA+u						
	Tr Date: 2/28/20 St Date: 3/3/20						
1,350,000.000	CATERPILLAR FINANCIAL FRN	14913Q2P3	1,350,000.00	1,352,189.09	2,189.09	100.162	0.34%
	Mat: 9/7/21 Cpn: 0.53%		0.00	455.40			
	Moody's: A3 S&P: A Fitch: A						
	Tr Date: 9/4/18 St Date: 9/7/18						
1,250,000.000	JOHN DEERE CAPITAL CORP FRN	24422EUJ6	1,250,000.00	1,253,094.45	3,094.45	100.248	0.32%
	Mat: 9/10/21 Cpn: 0.51%		0.00	371.51			
	Moody's: A2 S&P: A Fitch: A						
	Tr Date: 9/5/18 St Date: 9/10/18						
450,000.000	GILEAD SCIENCES FRN	375558BU6	450,000.00	450,167.09	167.09	100.037	0.11%
	Mat: 9/17/21 Cpn: 0.37%		0.00	4.63			
	Moody's: A3 S&P: Fitch:						
	Tr Date: 9/23/20 St Date: 9/30/20						
1,185,000.000	WELLS FARGO FRN	94988J5U7	1,185,000.00	1,188,594.82	3,594.82	100.303	0.30%
	Mat: 10/22/21 Cpn: 0.77%		0.00	1,794.30			
	Moody's: Aa2 S&P: A+ Fitch: AA-						
	Tr Date: 10/16/18 St Date: 10/23/18						
1,000,000.000	TRUIST BANK	86787EBA4	1,014,060.00	1,002,350.00	(11,710.00)	100.235	0.26%
	Mat: 10/26/21 Cpn: 3.53%		881.25	15,177.08			
	Moody's: A2 S&P: A Fitch: A+						
	Tr Date: 11/1/19 St Date: 11/5/19						
1,215,000.000	TD AMERITRADE FRN	87236YAG3	1,215,000.00	1,219,356.99	4,356.99	100.359	0.31%
	Mat: 11/1/21 Cpn: 0.68%		0.00	1,402.01			
	Moody's: A2 S&P: A Fitch:						
	Tr Date: 10/30/18 St Date: 11/1/18						
960,000.000	CATERPILLAR FINANCIAL FRN	14913Q3D9	960,000.00	961,442.62	1,442.62	100.150	0.25%
	Mat: 11/12/21 Cpn: 0.46%		0.00	609.17			
	Moody's: A3 S&P: A Fitch: A						
	Tr Date: 1/9/20 St Date: 1/13/20						

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
1,000,000.000	CITIGROUP Mat: 1/14/22 Cpn: 4.50% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 7/27/20 St Date: 7/29/20	172967FT3	1,058,710.00 1,875.00	1,051,580.00 9,625.00	(7,130.00)	105.158	0.27%
377,000.000	MORGAN STANLEY FRN Mat: 1/20/22 Cpn: 1.45% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 1/17/17 St Date: 1/20/17	61746BEE2	377,000.00 0.00	378,109.13 1,109.82	1,109.13	100.294	0.10%
1,904,000.000	NATL RURAL UTILITIES Mat: 1/21/22 Cpn: 1.75% Moody's: A2 S&P: A Fitch: A Tr Date: 1/22/20 St Date: 2/5/20	63743HET5	1,902,324.48 0.00	1,939,709.52 7,034.22	37,385.04	101.876	0.50%
1,030,000.000	US BANK CINCINNATI Mat: 1/21/22 Cpn: 1.80% Moody's: A1 S&P: AA- Fitch: AA- Tr Date: 1/16/20 St Date: 1/21/20	90331HPJ6	1,029,639.50 0.00	1,048,936.55 3,605.00	19,297.05	101.839	0.27%
1,000,000.000	BANK OF AMERICA Mat: 1/24/22 Cpn: 5.70% Moody's: A2 S&P: A- Fitch: A+ Tr Date: 7/17/20 St Date: 7/21/20	06051GEM7	1,079,080.00 28,025.00	1,069,240.00 10,608.33	(9,840.00)	106.924	0.28%
1,000,000.000	GOLDMAN SACHS Mat: 1/24/22 Cpn: 5.75% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 7/16/20 St Date: 7/20/20	38141GGS7	1,077,120.00 28,111.11	1,068,405.00 10,701.39	(8,715.00)	106.841	0.28%
552,000.000	WELLS FARGO FRN Mat: 2/11/22 Cpn: 1.18% Moody's: A2 S&P: BBB+ Fitch: A+ Tr Date: 10/3/17 St Date: 10/5/17	949746SP7	557,944.56 1,027.10	553,305.20 924.72	(4,639.36)	100.237	0.14%
520,000.000	DUKE ENERGY FRN Mat: 2/18/22 Cpn: 0.43% Moody's: A2 S&P: A- Fitch: Tr Date: 8/17/20 St Date: 8/20/20	26442UAJ3	520,000.00 0.00	521,595.82 262.69	1,595.82	100.307	0.13%
1,330,000.000	CAPITAL ONE FINL FRN Mat: 3/9/22 Cpn: 1.19% Moody's: Baa1 S&P: BBB Fitch: A- Tr Date: 3/6/17 St Date: 3/9/17	14040HBM6	1,330,000.00 0.00	1,340,266.34 968.63	10,266.34	100.772	0.34%
1,325,000.000	CITIGROUP FRN Mat: 4/25/22 Cpn: 1.20% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 4/18/17 St Date: 4/25/17	172967LH2	1,325,000.00 0.00	1,338,164.23 2,925.93	13,164.23	100.994	0.34%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost / Purchased Accrued	Principal Market Value / Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
1,300,000.000	UNITED PARCEL SERVICE FRN Mat: 5/16/22 Cpn: 0.66% Moody's: A2 S&P: A- Fitch: Tr Date: 8/17/17 St Date: 8/22/17	911312BB1	1,306,617.00 367.07	1,305,990.35 1,096.55	(626.65)	100.461	0.33%
1,000,000.000	AMERICAN EXPRESS Mat: 5/20/22 Cpn: 2.75% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 7/27/20 St Date: 7/29/20	025816CD9	1,039,226.90 5,270.83	1,034,840.00 10,006.94	(4,386.90)	103.484	0.27%
1,000,000.000	WELLS FARGO FRN Mat: 5/27/22 Cpn: 0.87% Moody's: Aa2 S&P: A+ Fitch: AA- Tr Date: 5/20/19 St Date: 5/28/19	94988J5W3	1,000,000.00 0.00	1,002,968.34 846.81	2,968.34	100.297	0.26%
1,000,000.000	PNC BANK Mat: 7/22/22 Cpn: 2.23% Moody's: A2 S&P: A Fitch: A+ Tr Date: 7/31/20 St Date: 8/4/20	69353RFP8	1,018,190.00 744.00	1,014,350.00 4,278.00	(3,840.00)	101.435	0.26%
730,000.000	CHEVRON FRN Mat: 8/12/22 Cpn: 0.37% Moody's: Aa2 S&P: AA Fitch: Tr Date: 8/10/20 St Date: 8/12/20	166756AG1	730,000.00 0.00	730,150.77 371.98	150.77	100.021	0.19%
2,190,000.000	HONEYWELL Mat: 8/19/22 Cpn: 0.48% Moody's: A2 S&P: A Fitch: A Tr Date: 8/17/20 St Date: 8/19/20	438516CC8	2,190,000.00 0.00	2,193,887.25 1,234.07	3,887.25	100.178	0.56%
225,000.000	HONEYWELL FRN Mat: 8/19/22 Cpn: 0.50% Moody's: A2 S&P: A Fitch: A Tr Date: 8/17/20 St Date: 8/19/20	438516CD6	225,000.00 0.00	225,159.91 133.77	159.91	100.071	0.06%
1,015,000.000	PNC BANK FRN Mat: 12/9/22 Cpn: 0.67% Moody's: A2 S&P: A Fitch: A+ Tr Date: 12/4/19 St Date: 12/9/19	69353RFR4	1,015,000.00 0.00	1,018,548.80 416.67	3,548.80	100.350	0.26%
1,015,000.000	MORGAN STANLEY FRN Mat: 1/20/23 Cpn: 0.77% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 1/16/20 St Date: 1/22/20	6174468K8	1,015,000.00 0.00	1,031,240.20 1,533.04	16,240.20	101.600	0.26%
570,000.000	GOLDMAN SACHS FRN Mat: 2/23/23 Cpn: 1.01% Moody's: A3 S&P: BBB+ Fitch: A Tr Date: 8/13/20 St Date: 8/17/20	38141GWU4	571,898.10 1,458.07	572,183.67 605.35	285.57	100.383	0.15%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security			Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
745,000.000	PNC BANK FRN			69353RFU7	745,000.00	746,064.84	1,064.84	100.143	0.19%
	Mat: 2/24/23	Cpn: 0.58%			0.00	456.99			
	Moody's: A2	S&P: A	Fitch: A+						
	Tr Date: 2/20/20	St Date: 2/25/20							
610,000.000	CHEVRON FRN			166764BU3	610,000.00	622,323.07	12,323.07	102.020	0.16%
	Mat: 5/11/23	Cpn: 1.15%			0.00	995.95			
	Moody's: Aa2	S&P: AA	Fitch:						
	Tr Date: 5/7/20	St Date: 5/11/20							
950,000.000	INTERCONTINENTALEXCHANGE FRN			45866FAR5	950,000.00	955,942.97	5,942.97	100.626	0.24%
	Mat: 6/15/23	Cpn: 0.90%			0.00	1,000.83			
	Moody's: A3	S&P: BBB+	Fitch:						
	Tr Date: 8/17/20	St Date: 8/20/20							
1,000,000.000	FLORIDA POWER & LIGHT FRN			341081GA9	1,000,000.00	1,000,798.91	798.91	100.080	0.26%
	Mat: 7/28/23	Cpn: 0.64%			0.00	1,103.31			
	Moody's: A1	S&P: A	Fitch:						
	Tr Date: 7/28/20	St Date: 7/31/20							
745,000.000	CHEVRON FRN			166756AK2	745,000.00	746,646.37	1,646.37	100.221	0.19%
	Mat: 8/11/23	Cpn: 0.46%			0.00	472.74			
	Moody's: Aa2	S&P: AA	Fitch:						
	Tr Date: 8/10/20	St Date: 8/12/20							
595,000.000	SOUTHERN CAL GAS FRN			842434CV2	595,000.00	594,875.35	(124.65)	99.979	0.15%
	Mat: 9/14/23	Cpn: 0.57%			0.00	94.16			
	Moody's: A2	S&P: A	Fitch: A+						
	Tr Date: 9/14/20	St Date: 9/21/20							
300,000.000	PPL ELECTRIC UTILITIES FRN			69351UAX1	300,000.00	299,729.28	(270.72)	99.910	0.08%
	Mat: 9/28/23	Cpn: 0.00%			0.00	0.00			
	Moody's: A1	S&P: A	Fitch:						
	Tr Date: 9/28/20	St Date: 10/1/20							
190,000.000	GILEAD SCIENCES FRN			375558BV4	190,000.00	190,240.13	240.13	100.126	0.05%
	Mat: 9/29/23	Cpn: 0.00%			0.00	0.00			
	Moody's: A3	S&P:	Fitch:						
	Tr Date: 9/23/20	St Date: 9/30/20							
1,000,000.000	JPMORGAN CHASE FRN			46625HRW2	1,014,470.00	1,015,868.00	1,398.00	101.587	0.26%
	Mat: 10/24/23	Cpn: 1.49%			4,625.51	2,862.54			
	Moody's: A2	S&P: A-	Fitch: AA-						
	Tr Date: 7/2/20	St Date: 7/7/20							
2,000,000.000	BANK OF AMERICA FRN			06051GHE2	2,004,364.00	2,009,132.00	4,768.00	100.457	0.51%
	Mat: 3/5/24	Cpn: 1.04%			3,039.72	1,326.33			
	Moody's: A2	S&P: A-	Fitch: A+						
	Tr Date: 7/22/20	St Date: 7/24/20							

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
Total for Credit			**48,766,020.19** **159,971.09**	**48,854,063.44** **179,008.63**	**88,043.25**		**12.51%**
Mortgage-Backed							
444,181.038	NGN 2010-R1 1A 1MOFRN NCUA GNTD Mat: 10/7/20 Cpn: 0.60% Moody's: Aaa S&P: AA+ Fitch: AAA Tr Date: 6/10/19 St Date: 6/12/19	62888VAA6	444,875.07 176.97	444,137.51 201.46	(737.56)	99.990	0.11%
5,329,405.507	NGN 2010-R2 2A 1MOFRN NCUA GNTD Mat: 11/5/20 Cpn: 0.62% Moody's: Aaa S&P: AA+ Fitch: AAA Tr Date: 9/25/19 St Date: 9/27/19	62888UAB6	5,333,291.59 1,794.57	5,329,650.66 2,497.16	(3,640.93)	100.005	1.36%
5,386,436.748	NGN 2010-R3 2A 1MOFRN NCUA GNTD Mat: 12/8/20 Cpn: 0.71% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 10/17/16 St Date: 10/20/16	62888WAB2	5,404,789.63 3,899.97	5,386,598.34 2,887.47	(18,191.29)	100.003	1.37%
2,823,544.740	FHMS K015 A2 CMBS Mat: 7/25/21 Cpn: 3.23% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 6/30/20 St Date: 7/6/20	3137AH6C7	2,887,074.50 1,266.67	2,872,369.48 7,600.04	(14,705.03)	101.729	0.73%
52,667.817	FHMS KI01 A CMBS 1MOFRN Mat: 9/25/22 Cpn: 0.32% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 3/19/18 St Date: 3/22/18	3137FEC81	52,692.51 94.17	52,678.61 2.78	(13.89)	100.021	0.01%
53,944.795	FHMS KI02 A 1MOFRN CMBS Mat: 2/25/23 Cpn: 0.36% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 8/1/18 St Date: 8/14/18	3137FGZN8	53,944.80 0.00	53,935.89 3.21	(8.90)	99.984	0.01%
864,843.353	FHMS KI04 A 1MOFRN CMBS Mat: 7/25/24 Cpn: 0.51% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 8/8/19 St Date: 8/21/19	3137FNAV2	864,843.35 0.00	866,871.41 73.24	2,028.06	100.235	0.22%
1,684,130.273	FHMS KI05 A Mat: 7/25/24 Cpn: 0.49% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 1/16/20 St Date: 1/28/20	3137FQXG3	1,684,130.27 0.00	1,690,817.95 137.01	6,687.68	100.397	0.43%
2,010,000.000	FHMS KI06 A 1MOFRN CMBS Mat: 3/25/25 Cpn: 0.37% Moody's: Aaa S&P: AA+u Fitch: AAA Tr Date: 8/11/20 St Date: 8/25/20	3137FVNA6	2,010,000.00 0.00	2,013,437.10 125.58	3,437.10	100.171	0.51%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security	Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
Total for Mortgage-Backed			**18,735,641.72** **7,232.35**	**18,710,496.96** **13,527.96**	**(25,144.76)**		**4.78%**
Asset-Backed							
248,495.384	JOHN DEERE 2020-A A1 EQP Mat: 3/15/21 Cpn: 1.10% Moody's: P-1 S&P: Fitch: F1+ Tr Date: 3/4/20 St Date: 3/11/20	47789KAA1	248,495.38 0.00	248,641.75 121.49	146.36	100.059	0.06%
175,387.803	TOYOTA 2020-B A1 CAR Mat: 5/17/21 Cpn: 1.14% Moody's: P-1 S&P: A-1+ Fitch: Tr Date: 4/20/20 St Date: 4/29/20	89239RAA4	175,387.80 0.00	175,455.68 88.97	67.88	100.039	0.04%
841,129.041	SDART 2020-2 A1 CAR Mat: 7/15/21 Cpn: 0.24% Moody's: P-1 S&P: Fitch: F1+ Tr Date: 7/14/20 St Date: 7/22/20	80285RAA6	841,129.04 0.00	841,132.41 90.11	3.36	100.000	0.21%
2,647,635.470	TOYOTA 2020-C A1 CAR Mat: 8/16/21 Cpn: 0.20% Moody's: P-1 S&P: A-1+ Fitch: Tr Date: 7/21/20 St Date: 7/27/20	89237VAE9	2,647,635.47 0.00	2,647,675.18 237.22	39.71	100.002	0.68%
2,140,000.000	MERCEDES 2020-B A1 LEASE Mat: 10/15/21 Cpn: 0.18% Moody's: S&P: (P)A-1+ Fitch: F1+ Tr Date: 9/15/20 St Date: 9/23/20	58769EAA6	2,140,000.00 0.00	2,140,000.00 87.58	0.00	100.000	0.55%
3,700,000.000	SDART 2020-3 A1 CAR Mat: 10/15/21 Cpn: 0.28% Moody's: P-1 S&P: Fitch: F1+ Tr Date: 9/15/20 St Date: 9/23/20	80285WAA5	3,700,000.00 0.00	3,699,859.40 231.55	(140.60)	99.996	0.94%
2,950,000.000	HONDA 2020-3 A1 CAR Mat: 10/18/21 Cpn: 0.19% Moody's: S&P: A-1+ Fitch: F1+ Tr Date: 9/22/20 St Date: 9/29/20	43813KAA0	2,950,000.00 0.00	2,950,050.15 30.94	50.15	100.002	0.75%
1,885,150.258	MERCEDES 2019-A A3 LEASE Mat: 11/15/21 Cpn: 3.10% Moody's: Aaa S&P: AAA Fitch: Tr Date: 7/2/20 St Date: 7/7/20	58772TAC4	1,904,075.40 3,571.31	1,898,847.76 2,597.32	(5,227.64)	100.727	0.48%
699,586.303	TOYOTA 2019-B A2A CAR Mat: 2/15/22 Cpn: 2.59% Moody's: Aaa S&P: AAA Fitch: Tr Date: 5/5/20 St Date: 5/7/20	89239JAB0	704,040.70 1,107.29	702,788.31 805.30	(1,252.39)	100.458	0.18%

Portfolio Positions

as of September 30, 2020

Currency: USD

Units	Security			Identifier	Original Principal Cost Purchased Accrued	Principal Market Value Accrued Income	Gain / (Loss) from Cost	Market Price	Percent of Portfolio
1,560,000.000	BMW 2018-1 A4 LEASE			05586CAD6	1,578,403.13	1,575,990.00	(2,413.13)	101.025	0.40%
	Mat: 3/21/22	Cpn: 3.36%			3,785.60	1,601.60			
	Moody's: Aaa	S&P: AAA	Fitch:						
	Tr Date: 9/14/20	St Date: 9/16/20							
926,446.323	VOLKSWAGEN 2019-A A2A LEASE			92867XAB2	933,467.05	933,587.37	120.32	100.771	0.24%
	Mat: 3/21/22	Cpn: 2.00%			823.51	566.16			
	Moody's:	S&P: AAA	Fitch: AAA						
	Tr Date: 7/1/20	St Date: 7/6/20							
403,644.993	TOYOTA 2019-C A2B CAR 1MOFRN			89238UAC4	403,644.99	403,856.50	211.51	100.052	0.10%
	Mat: 4/15/22	Cpn: 0.35%			0.00	63.22			
	Moody's: Aaa	S&P: AAA	Fitch:						
	Tr Date: 8/6/19	St Date: 8/14/19							
1,747,835.339	MERCEDES 2019-1 A2A CAR			58769TAB1	1,760,602.73	1,760,346.34	(256.38)	100.716	0.45%
	Mat: 6/15/22	Cpn: 2.04%			297.13	1,584.70			
	Moody's: Aaa	S&P: AAA	Fitch:						
	Tr Date: 8/17/20	St Date: 8/18/20							
Total for Asset-Backed					**19,986,881.69**	**19,978,230.85**	**(8,650.84)**		**5.10%**
					9,584.85	**8,106.15**			
Grand Total					**391,440,432.97**	**391,597,402.70**	**156,969.73**		**100.00%**
					231,954.81	**489,967.96**			

MetLife Investment Management

Source Account Name	Security ID	Security Description 1	Security Description 2	Sector	Shares/Par	Base Cost	Accrued Interest	Base Market Value	Base Unrealized Gain	Base Unrealized Loss	Percent of Asset	Moody's Rating	S&P Rating	Fitch Rating
CALOPTIMA EC	GL-110000	CASH			0.0000	1,156,991.34	0.00	1,156,991.34	0.00	0.00	0.00			
CALOPTIMA EC	02587AAL8	AMERICAN EXPRESS CREDIT AC 2 A	VAR RT 09/16/2024 DD 02/21/17	Asset Backed	3,255,000.0000	3,269,079.33	871.44	3,268,613.71	0.00	-465.62	0.84	Aaa	NR	AAA
CALOPTIMA EC	05586CAC8	BMW VEHICLE LEASE TRUST 2 1 A3	3.260% 07/20/2021 DD 10/17/18	Asset Backed	882,475.5750	887,065.44	879.04	886,639.09	0.00	-426.35	0.23	Aaa	AAA	NR
CALOPTIMA EC	05586CAC8	BMW VEHICLE LEASE TRUST 2 1 A3	3.260% 07/20/2021 DD 10/17/18	Asset Backed	588,644.0750	591,705.54	586.36	591,421.30	0.00	-284.24	0.15	Aaa	AAA	NR
CALOPTIMA EC	05586VAC6	BMW VEHICLE LEASE TRUST 2 1 A3	2.840% 11/22/2021 DD 03/20/19	Asset Backed	74,578.0620	74,885.94	64.72	75,095.13	209.19	0.00	0.02	Aaa	AAA	NR
CALOPTIMA EC	05586VAC6	BMW VEHICLE LEASE TRUST 2 1 A3	2.840% 11/22/2021 DD 03/20/19	Asset Backed	1,040,624.1220	1,046,116.73	903.03	1,047,838.97	1,722.24	0.00	0.27	Aaa	AAA	NR
CALOPTIMA EC	05586VAC6	BMW VEHICLE LEASE TRUST 2 1 A3	2.840% 11/22/2021 DD 03/20/19	Asset Backed	255,820.0960	257,133.64	221.99	257,593.75	460.11	0.00	0.07	Aaa	AAA	NR
CALOPTIMA EC	161571HD9	CHASE ISSUANCE TRUST A3 A3	VAR RT 06/15/2023 DD 06/23/16	Asset Backed	2,400,000.0000	2,412,091.74	749.21	2,409,151.20	0.00	-2,940.54	0.62	NR	AAA	AAA
CALOPTIMA EC	161571HN7	CHASE ISSUANCE TRUST A1 A1	VAR RT 04/17/2023 DD 05/10/18	Asset Backed	2,000,000.0000	2,001,174.90	313.23	2,001,717.80	542.90	0.00	0.51	NR	AAA	AAA
CALOPTIMA EC	362569AH8	GM FINANCIAL AUTOMOBILE L 3 A1	0.178% 10/20/2021 DD 09/29/20	Asset Backed	12,000,000.0000	12,000,000.00	118.76	11,999,536.80	0.00	-463.20	3.07	NR	NR	NR
CALOPTIMA EC	43813FAC7	HONDA AUTO RECEIVABLES 20 4 A3	2.050% 11/22/2021 DD 11/29/17	Asset Backed	136,624.5940	136,690.02	77.80	137,109.06	419.04	0.00	0.04	Aaa	NR	AAA
CALOPTIMA EC	43813KAA0	HONDA AUTO RECEIVABLES 20 3 A1	0.189% 10/18/2021 DD 09/29/20	Asset Backed	12,750,000.0000	12,750,000.00	133.71	12,749,813.85	0.00	-186.15	3.26	NR	NR	NR
CALOPTIMA EC	43814PAC4	HONDA AUTO RECEIVABLES 20 3 A3	1.790% 09/20/2021 DD 09/29/17	Asset Backed	778,880.1870	779,178.63	503.46	780,188.94	1,010.31	0.00	0.20	NR	AAA	AAA
CALOPTIMA EC	43814WAB1	HONDA AUTO RECEIVABLES 20 1 A2	2.750% 09/20/2021 DD 02/27/19	Asset Backed	14,796.9130	14,828.94	14.69	14,833.50	4.56	0.00	0.00	NR	AAA	AAA
CALOPTIMA EC	43814WAB1	HONDA AUTO RECEIVABLES 20 1 A2	2.750% 09/20/2021 DD 02/27/19	Asset Backed	294,329.8860	295,192.19	292.29	295,057.58	0.00	-134.61	0.08	NR	AAA	AAA
CALOPTIMA EC	47789KAA1	JOHN DEERE OWNER TRUST 20 A A1	1.100% 03/15/2021 DD 03/11/20	Asset Backed	480,958.8000	480,958.80	235.14	481,232.85	274.05	0.00	0.12	Aaa	NR	AAA
CALOPTIMA EC	58769EAA6	MERCEDES-BENZ AUTO LEASE B A1	0.184% 10/15/2021 DD 09/23/20	Asset Backed	3,000,000.0000	3,000,000.00	122.77	2,999,992.20	0.00	-7.80	0.77	NR	NR	NR
CALOPTIMA EC	58769QAB7	MERCEDES-BENZ AUTO LEASE B A2	2.010% 12/15/2021 DD 11/20/19	Asset Backed	1,845,263.7000	1,846,347.23	1,648.44	1,852,277.73	5,930.50	0.00	0.47	NR	AAA	AAA
CALOPTIMA EC	65479KAC4	NISSAN AUTO RECEIVABLES A A2B	VAR RT 01/18/2022 DD 02/13/19	Asset Backed	147,634.2250	147,649.12	19.88	147,632.79	0.00	-16.33	0.04	Aaa	NR	AAA
CALOPTIMA EC	80285RAA6	SANTANDER DRIVE AUTO RECE 2 A1	0.241% 07/15/2021 DD 07/22/20	Asset Backed	9,365,648.3590	9,365,998.22	1,003.37	9,365,998.22	0.00	0.00	2.40	Aaa	NR	AAA
CALOPTIMA EC	80285WAA5	SANTANDER DRIVE AUTO RECE 3 A1	0.282% 10/15/2021 DD 09/23/20	Asset Backed	5,000,000.0000	5,000,000.00	312.90	4,999,692.00	0.00	-308.00	1.28	NR	NR	NR
CALOPTIMA EC	89239RAA4	TOYOTA AUTO RECEIVABLES 2 B A1	1.141% 05/17/2021 DD 04/29/20	Asset Backed	326,134.3200	326,134.32	165.43	326,258.84	124.52	0.00	0.08	NR	NR	NR
CALOPTIMA EC	51501GE31	LANDESBANK BADEN C/D	0.210% 11/06/2020 DD 08/03/20	CD	5,000,000.0000	5,000,049.91	1,720.83	5,000,049.91	0.00	0.00	1.28	P-1	NR	F1
CALOPTIMA EC	51501GE80	LANDESBANK BADEN C/D	0.190% 10/06/2020 DD 08/06/20	CD	5,300,000.0000	5,299,992.66	1,566.44	5,299,992.66	0.00	0.00	1.36	P-1	NR	F1
CALOPTIMA EC	65602VV29	NORINCHUKIN BK C/D	0.210% 11/12/2020 DD 08/12/20	CD	5,000,000.0000	4,999,999.17	1,458.33	4,999,999.17	0.00	0.00	1.28	P-1	A-1	NA
CALOPTIMA EC	83050PLC1	SKANDINAVISKA ENSK INSTL C/D	0.240% 10/01/2020 DD 06/24/20	CD	6,000,000.0000	5,999,999.92	3,960.00	5,999,999.92	0.00	0.00	1.53	P-1	A-1	F1+
CALOPTIMA EC	87019VE37	SWEDBANK (SPARBANK) INSTL C/D	0.530% 10/30/2020 DD 04/30/20	CD	6,200,000.0000	6,201,845.96	14,056.78	6,201,845.96	0.00	0.00	1.59	P-1	A-1	F1+
CALOPTIMA EC	9127962R9	U S TREASURY BILL	0.000% 10/15/2020 DD 04/16/20	US Government	32,000,000.0000	31,998,805.26	0.00	31,998,805.26	0.00	0.00	8.18	Govt	A-1+	Govt
CALOPTIMA EC	9127964G1	U S TREASURY BILL	0.000% 10/06/2020 DD 05/05/20	US Government	20,500,000.0000	20,499,753.56	0.00	20,499,753.56	0.00	0.00	5.24	Govt	A-1+	Govt
CALOPTIMA EC	9127964H9	U S TREASURY BILL	0.000% 10/13/2020 DD 05/12/20	US Government	25,000,000.0000	24,999,224.85	0.00	24,999,224.85	0.00	0.00	6.39	Govt	A-1+	Govt
CALOPTIMA EC	9127964H9	U S TREASURY BILL	0.000% 10/13/2020 DD 05/12/20	US Government	25,000,000.0000	24,999,241.91	0.00	24,999,241.91	0.00	0.00	6.39	Govt	A-1+	Govt
CALOPTIMA EC	9127964H9	U S TREASURY BILL	0.000% 10/13/2020 DD 05/12/20	US Government	25,000,000.0000	24,999,241.91	0.00	24,999,241.91	0.00	0.00	6.39	Govt	A-1+	Govt
CALOPTIMA EC	9127964K2	U S TREASURY BILL	0.000% 10/27/2020 DD 05/26/20	US Government	25,000,000.0000	24,998,465.31	0.00	24,998,465.31	0.00	0.00	6.39	Govt	A-1+	Govt
CALOPTIMA EC	30229AQR3	EXXON CORP DISC	03/25/2021	CP	8,000,000.0000	7,992,611.06	0.00	7,992,611.06	0.00	0.00	2.04	P-1	A-1+	NR
CALOPTIMA EC	60683BK44	MITSUBISHI TR & BKG INSTL C/D	0.220% 02/04/2021 DD 09/02/20	CD	9,000,000.0000	8,999,685.08	1,595.00	8,999,685.08	0.00	0.00	2.30	P-1	A-1	F1
CALOPTIMA EC	89114NKG9	TORONTO-DOMINION INSTL C/D	0.550% 02/01/2021 DD 05/04/20	CD	3,000,000.0000	3,003,367.86	6,875.00	3,003,367.86	0.00	0.00	0.77	P-1	A-1+	F1+
CALOPTIMA EC	3137FGZN8	FHLMC MULTICLASS MTG KI02 A	VAR RT 02/25/2023 DD 08/14/18	CMBS	134,861.9900	134,821.23	8.02	134,827.25	6.02	0.00	0.03	Agency	AA+	Agency
CALOPTIMA EC	3137FMTW2	FHLMC MULTICLASS MTG Q009 A	VAR RT 04/25/2024 DD 07/19/19	CMBS	2,085,412.5300	2,085,412.53	176.02	2,083,036.62	0.00	-2,375.91	0.53	Agency	AA+	Agency
CALOPTIMA EC	31381Q6B7	FNMA POOL #0468066	4.295% 06/01/2021 DD 06/01/11	CMBS	443,725.6150	449,745.72	1,588.17	451,231.09	1,485.37	0.00	0.12	Agency	AA+	Agency
CALOPTIMA EC	31381TBJ8	FNMA POOL #0469941	3.300% 12/01/2021 DD 12/01/11	CMBS	1,520,660.3300	1,553,861.48	4,181.82	1,546,184.07	0.00	-7,677.41	0.40	Agency	AA+	Agency
CALOPTIMA EC	3138EJRP5	FNMA POOL #0AL2293	VAR RT 06/01/2021 DD 08/01/12	CMBS	234,852.0600	242,715.26	857.21	236,722.95	0.00	-5,992.31	0.06	Agency	AA+	Agency
CALOPTIMA EC	025816BU2	AMERICAN EXPRESS CO	3.375% 05/17/2021 DD 05/17/18	Corporates	5,000,000.0000	5,041,881.15	62,812.50	5,081,425.35	39,544.20	0.00	1.30	A3	BBB+	A
CALOPTIMA EC	025816CE7	AMERICAN EXPRESS CO	VAR RT 05/20/2022 DD 05/20/19	Corporates	2,000,000.0000	2,000,000.00	2,043.87	2,012,033.82	12,033.82	0.00	0.51	A3	BBB+	A
CALOPTIMA EC	06051GFT1	BANK OF AMERICA CORP	2.625% 10/19/2020 DD 10/19/15	Corporates	1,930,000.0000	1,931,603.00	22,798.13	1,932,102.81	499.81	0.00	0.49	A2	A-	A+
CALOPTIMA EC	06051GGU7	BANK OF AMERICA CORP	VAR RT 10/01/2021 DD 09/18/17	Corporates	6,000,000.0000	6,000,000.24	14,507.33	6,000,000.00	0.00	-0.24	1.53	A2	A-	A+
CALOPTIMA EC	17308CC38	CITIGROUP INC	VAR RT 11/04/2022 DD 11/04/19	Corporates	5,000,000.0000	5,013,725.38	7,384.69	5,015,395.75	1,670.37	0.00	1.28	A3	BBB+	A
CALOPTIMA EC	17401QAN1	CITIZENS BANK NA/PROVIDENCE RI	2.250% 10/30/2020 DD 11/01/17	Corporates	3,500,000.0000	3,500,000.24	33,031.25	3,501,496.57	1,496.33	0.00	0.90	Baa1	A-	BBB+
CALOPTIMA EC	22550UAA9	CREDIT SUISSE AG/NEW YORK NY	VAR RT 02/04/2022 DD 02/04/20	Corporates	2,350,000.0000	2,350,000.00	2,037.61	2,354,788.08	4,788.08	0.00	0.60	A1	A+	A
CALOPTIMA EC	31677QBP3	FIFTH THIRD BANK NA	VAR RT 07/26/2021 DD 07/26/18	Corporates	2,200,000.0000	2,190,972.28	2,893.93	2,205,863.75	14,891.47	0.00	0.56	A3	A-	A-
CALOPTIMA EC	369550BF4	GENERAL DYNAMICS CORP	VAR RT 05/11/2021 DD 05/11/18	Corporates	3,975,000.0000	3,969,202.87	3,583.31	3,984,042.57	14,839.70	0.00	1.02	A2	A	NR
CALOPTIMA EC	38141GWD2	GOLDMAN SACHS GROUP INC/THE	VAR RT 04/26/2022 DD 01/26/17	Corporates	2,794,000.0000	2,806,979.71	7,159.26	2,805,557.63	0.00	-1,422.08	0.72	A3	BBB+	A
CALOPTIMA EC	38143U8F1	GOLDMAN SACHS GROUP INC/THE	2.875% 02/25/2021 DD 02/25/16	Corporates	4,000,000.0000	4,032,346.07	11,500.00	4,032,922.88	576.81	0.00	1.03	A3	BBB+	A
CALOPTIMA EC	45818WCP9	INTER-AMERICAN DEVELOPMENT BAN	VAR RT 09/16/2022 DD 09/18/19	Corporates	6,440,000.0000	6,440,000.00	948.10	6,438,712.00	0.00	-1,288.00	1.65	Aaa	AAA	AAA
CALOPTIMA EC	45818WCP9	INTER-AMERICAN DEVELOPMENT BAN	VAR RT 09/16/2022 DD 09/18/19	Corporates	1,000,000.0000	1,000,202.25	147.22	999,800.00	0.00	-402.25	0.26	Aaa	AAA	AAA
CALOPTIMA EC	459058EW9	INTERNATIONAL BANK FOR RECONST	1.625% 03/09/2021 DD 03/09/16	Corporates	4,500,000.0000	4,528,705.92	4,468.75	4,527,640.85	0.00	-1,065.07	1.16	Aaa	AAA	AAA
CALOPTIMA EC	459200KD2	INTERNATIONAL BUSINESS MACHINE	VAR RT 05/13/2021 DD 05/15/19	Corporates	1,693,000.0000	1,692,118.96	1,505.90	1,697,190.18	5,071.22	0.00	0.43	A2	A	NR
CALOPTIMA EC	45950KCJ7	INTERNATIONAL FINANCE CORP	1.125% 07/20/2021 DD 07/20/16	Corporates	4,800,000.0000	4,836,676.96	10,650.00	4,835,139.02	0.00	-1,537.94	1.24	Aaa	AAA	NR
CALOPTIMA EC	55279HAM2	MANUFACTURERS & TRADERS TRUST	VAR RT 05/18/2022 DD 05/18/17	Corporates	2,740,000.0000	2,755,453.22	2,957.07	2,760,915.30	5,462.08	0.00	0.71	A3	A	A
CALOPTIMA EC	6174468H5	MORGAN STANLEY	VAR RT 06/10/2022 DD 06/10/19	Corporates	3,000,000.0000	3,007,536.19	1,616.05	3,007,262.10	0.00	-274.09	0.77	A3	BBB+	A
CALOPTIMA EC	61746BEE2	MORGAN STANLEY	VAR RT 01/20/2022 DD 01/20/17	Corporates	2,067,000.0000	2,071,542.14	5,918.18	2,073,019.76	1,477.62	0.00	0.53	A3	BBB+	A
CALOPTIMA EC	61746BEE2	MORGAN STANLEY	VAR RT 01/20/2022 DD 01/20/17	Corporates	1,538,000.0000	1,542,697.83	4,403.56	1,542,479.15	0.00	-218.68	0.39	A3	BBB+	A
CALOPTIMA EC	69353REW4	PNC BANK NA	2.150% 04/29/2021 DD 04/29/16	Corporates	1,500,000.0000	1,503,558.75	13,616.67	1,513,844.55	10,285.80	0.00	0.39	A2	A	A+
CALOPTIMA EC	842434CV2	SOUTHERN CALIFORNIA GAS CO	VAR RT 09/14/2023 DD 09/21/20	Corporates	1,815,000.0000	1,815,000.00	287.24	1,814,275.25	0.00	-724.75	0.46	A2	A	A+
CALOPTIMA EC	86787EBD8	TRUIST BANK	VAR RT 05/17/2022 DD 05/17/19	Corporates	3,500,000.0000	3,500,000.00	3,817.08	3,522,811.32	22,811.32	0.00	0.90	A2	A	A+
CALOPTIMA EC	92343VDX9	VERIZON COMMUNICATIONS INC	VAR RT 03/16/2022 DD 03/16/17	Corporates	3,674,000.0000	3,716,499.94	1,902.56	3,716,162.82	0.00	-337.12	0.95	Baa1	BBB+	A-
CALOPTIMA EC	949746SB8	WELLS FARGO & CO	VAR RT 07/26/2021 DD 07/25/16	Corporates	2,000,000.0000	2,010,130.50	4,808.35	2,014,600.00	4,469.50	0.00	0.52	A2	BBB+	A+
CALOPTIMA EC	604617CB4	MIRACOSTA CA CMNTY CLG DIST	0.150% 11/01/2020 DD 09/08/20	Municipals	1,050,000.0000	1,050,000.00	100.63	1,050,000.00	0.00	0.00	0.27	Aaa	AAA	NR
CALOPTIMA EC	88276SJC5	TEXAS PUBLIC FIN TAXABLE	0.230% 12/09/2020 DD 09/10/20	Municipals	3,000,000.0000	3,000,000.00	396.99	3,000,000.00	0.00	0.00	0.77	P-1	A-1	F1+

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MetLife Investment Management

Source Account Name	Security ID	Security Description 1	Security Description 2	Sector	Shares/Par	Base Cost	Accrued Interest	Base Market Value	Base Unrealized Gain	Base Unrealized Loss	Percent of Asset	Moody's Rating	S&P Rating	Fitch Rating
CALOPTIMA EC	283062DJ3	EL DORADO CA IRR DIST REVENUE	0.639% 03/01/2021 DD 06/23/20	Municipals	1,380,000.0000	1,380,000.00	734.85	1,380,000.00	0.00	0.00	0.35	Aa3	AA-	NR
CALOPTIMA EC	4212906J1	HAYWARD CA UNIF SCH DIST	0.300% 12/01/2020 DD 09/10/20	Municipals	4,000,000.0000	4,000,000.00	700.00	4,000,000.00	0.00	0.00	1.02	A1	A+	NR
CALOPTIMA EC	544587X94	LOS ANGELES CA MUNI IMPT CORPL	0.415% 11/01/2021 DD 08/20/20	Municipals	2,000,000.0000	2,000,000.00	945.28	2,000,440.00	440.00	0.00	0.51	NR	AA-	NR
CALOPTIMA EC	7092243K3	PENNSYLVANIA ST TURNPIKE COMMI	1.812% 12/01/2020 DD 02/26/20	Municipals	1,500,000.0000	1,500,000.00	9,060.00	1,500,000.00	0.00	0.00	0.38	A3	NR	A-
CALOPTIMA EC	797356BD3	SAN DIEGO CA UNIF SCH DIST	0.230% 01/01/2021 DD 08/27/20	Municipals	2,000,000.0000	2,000,000.00	434.44	2,000,000.00	0.00	0.00	0.51	Aa2	NR	NR
CALOPTIMA EC	882724QV2	TEXAS ST	1.514% 10/01/2020 DD 04/23/20	Municipals	3,470,000.0000	3,470,000.00	23,057.38	3,470,000.00	0.00	0.00	0.89	Aaa	AAA	NR
CALOPTIMA EC	923078CQ0	VENTURA CNTY CA PUBLIC FING AU	0.598% 11/01/2020 DD 06/11/20	Municipals	1,250,000.0000	1,250,000.00	2,284.03	1,250,000.00	0.00	0.00	0.32	Aa1	AA+	NR
CALOPTIMA EC	3133EL7F5	FEDERAL FARM CR BK CONS BD	0.180% 09/15/2022 DD 09/15/20	RMBS	7,500,000.0000	7,495,587.08	600.00	7,497,073.42	1,486.34	0.00	1.92	Agency	AA+	Agency
CALOPTIMA EC	3133EL7F5	FEDERAL FARM CR BK CONS BD	0.180% 09/15/2022 DD 09/15/20	RMBS	1,500,000.0000	1,498,970.30	120.00	1,499,414.69	444.39	0.00	0.38	Agency	AA+	Agency
CALOPTIMA EC	3134GVA40	FEDERAL HOME LN MTG CORP	0.350% 05/27/2022 DD 05/28/20	RMBS	2,000,000.0000	2,000,426.26	2,391.67	2,000,510.64	84.38	0.00	0.51	Agency	AA+	Agency
CALOPTIMA EC	3134GVG36	FEDERAL HOME LN MTG CORP	0.375% 06/08/2022 DD 06/08/20	RMBS	3,550,000.0000	3,550,694.38	4,178.65	3,551,232.42	538.04	0.00	0.91	Agency	AA+	Agency
CALOPTIMA EC	3134GWEH5	FEDERAL HOME LN MTG CORP	0.280% 07/27/2022 DD 07/27/20	RMBS	3,000,000.0000	2,999,452.65	1,493.33	2,999,538.75	86.10	0.00	0.77	Agency	AA+	Agency
CALOPTIMA EC	3137ABFH9	FHLMC MULTICLASS MTG KAIV A2	3.989% 06/25/2021 DD 06/01/11	RMBS	750,000.0000	758,313.12	2,493.13	761,151.15	2,838.03	0.00	0.19	Agency	AA+	Agency
CALOPTIMA EC	3137ADTJ6	FHLMC MULTICLASS MTG K014 A2	3.871% 04/25/2021 DD 08/01/11	RMBS	946,030.0000	952,484.38	3,051.74	952,546.16	61.78	0.00	0.24	Agency	AA+	Agency
CALOPTIMA EC	3137AFT77	FHLMC MULTICLASS MTG 3938 BE	2.000% 10/15/2021 DD 10/01/11	RMBS	1,581,809.9200	1,582,310.89	2,636.35	1,587,976.13	5,665.24	0.00	0.41	Agency	AA+	Agency
CALOPTIMA EC	3137B6ZM6	FHLMC MULTICLASS MTG K714 A2	VAR RT 10/25/2020 DD 01/01/14	RMBS	2,608.6440	3,109.17	6.60	2,608.26	0.00	-500.91	0.00	Aaa	AA+	Agency
CALOPTIMA EC	3137FQXG3	FHLMC MULTICLASS MTG KI05 A	VAR RT 07/25/2024 DD 01/28/20	RMBS	4,678,139.6000	4,678,139.60	384.10	4,687,581.02	9,441.42	0.00	1.20	Agency	AA+	Agency
CALOPTIMA EC	31397UPG8	FNMA GTD REMIC P/T 11-M1 FA	VAR RT 06/25/2021 DD 05/25/11	RMBS	415,021.3840	414,986.43	43.24	414,527.38	0.00	-459.05	0.11	Agency	AA+	Agency
CALOPTIMA EC	62888UAB6	NCUA GUARANTEED NOTES TR R2 2A	VAR RT 11/05/2020 DD 11/17/10	RMBS	3,121,479.2210	3,121,762.87	1,300.10	3,121,540.40	0.00	-222.47	0.80	Aaa	AA+	Agency
CALOPTIMA EC	62888VAA6	NCUA GUARANTEED NOTES TR R1 1A	VAR RT 10/07/2020 DD 10/27/10	RMBS	1,092,384.3430	1,092,389.11	440.41	1,092,270.30	0.00	-118.81	0.28	Aaa	AA+	AAA
CALOPTIMA EC	62888VAA6	NCUA GUARANTEED NOTES TR R1 1A	VAR RT 10/07/2020 DD 10/27/10	RMBS	315,443.8510	315,441.82	127.18	315,410.92	0.00	-30.90	0.08	Aaa	AA+	AAA
CALOPTIMA EC	62888VAA6	NCUA GUARANTEED NOTES TR R1 1A	VAR RT 10/07/2020 DD 10/27/10	RMBS	321,466.6410	321,469.36	129.60	321,433.08	0.00	-36.28	0.08	Aaa	AA+	AAA

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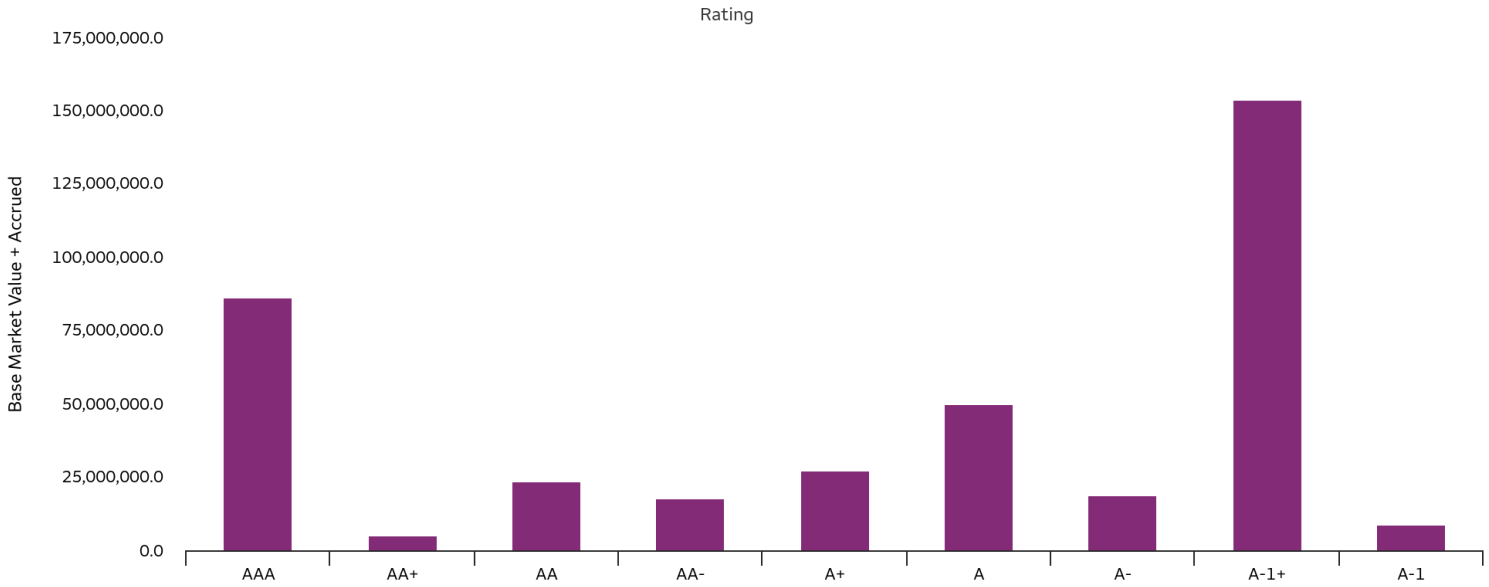
Credit Rating

US Dollar

As of 30 September 2020

WC-CalOptima
Account: XXXX2500
Investment Strategy: Short Duration Fixed Income
Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management



AAA

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
02587AAL8 AMXCA 2017-2 A	5,580,000.00	USD 02/15/2022	ABS	AAA	Aaa	NA	AAA	5,604,831.69	1.43%
05586VAC6 BMWLT 2019-1 A3	4,934,292.73	USD 11/22/2021	ABS	AAA	Aaa	AAA	NA	4,972,785.04	1.27%
17305EFY6 CCCIT 2016-A3 A3	4,380,000.00	USD 12/07/2021	ABS	AAA	Aaa	AAA	NA	4,405,422.85	1.12%
3137BAHA3 FHMS K-715 A2	1,536,596.42	USD 01/25/2021	FHLMC	AAA	Aaa	AA+	AAA	1,545,989.48	0.39%
316175108 FIDELITY IMM:GOVT I	23,083,672.97	USD 09/30/2020	MMFUND	AAA	Aaa	AAAm	AAA	23,083,672.97	5.88%
34153P7G7 FLORIDA ST BRD ED PUB ED	5,000,000.00	USD 06/01/2021	MUNI	AAA	Aaa	AAA	AAA	5,243,833.33	1.34%
43814UAC3 HAROT 2018-1 A3	2,621,060.60	USD 02/15/2022	ABS	AAA	Aaa	AAA	NA	2,646,333.74	0.67%
43814WAB1 HAROT 2019-1 A2	255,729.25	USD 09/20/2021	ABS	AAA	NA	AAA	AAA	256,615.47	0.07%
43814WAB1 HAROT 2019-1 A2	160,836.01	USD 09/20/2021	ABS	AAA	NA	AAA	AAA	161,393.38	0.04%

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Credit Rating

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WC-CalOptima
Account: XXXX2500
Investment Strategy: Short Duration Fixed Income
Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
4581X0CS5 INTER-AMERICAN DEVELOPMENT BANK	5,000,000.00	USD 03/15/2021	SUPRANATIONAL	AAA	Aaa	AAA	AAA	5,040,311.62	1.28%
459058FH1 INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPM	5,000,000.00	USD 05/24/2021	SUPRANATIONAL	AAA	Aaa	AAA	AAA	5,059,903.47	1.29%
459058FH1 INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPM	2,500,000.00	USD 05/24/2021	SUPRANATIONAL	AAA	Aaa	AAA	AAA	2,529,951.74	0.64%
459058FP3 INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPM	1,000,000.00	USD 09/20/2021	SUPRANATIONAL	AAA	Aaa	AAA	AAA	1,011,127.02	0.26%
459058GH0 INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPM	5,000,000.00	USD 07/23/2021	SUPRANATIONAL	AAA	Aaa	AAA	NA	5,128,972.22	1.31%
45950KCJ7 INTERNATIONAL FINANCE CORP	4,831,000.00	USD 07/20/2021	SUPRANATIONAL	AAA	Aaa	AAA	NA	4,877,084.74	1.24%
45950KCM0 INTERNATIONAL FINANCE CORP	5,000,000.00	USD 01/25/2021	SUPRANATIONAL	AAA	Aaa	AAA	NA	5,052,556.60	1.29%
58769QAB7 MBALT 2019-B A2	573,063.26	USD 12/15/2021	ABS	AAA	NA	AAA	AAA	575,753.47	0.15%
58772TAC4 MBALT 2019-A A3	1,721,841.57	USD 11/15/2021	ABS	AAA	Aaa	AAA	NA	1,736,609.94	0.44%
817409YB5 SEQUOIA CALIF UN HIGH SCH DIST	1,360,000.00	USD 07/01/2021	MUNI	AAA	Aaa	NA	NA	1,429,802.00	0.36%
89237RAD0 TAOT 2017-C A3	463,183.90	USD 11/15/2021	ABS	AAA	Aaa	AAA	NA	464,409.44	0.12%
92349GAB7 VZOT 2019-B A1B	3,110,000.00	USD 12/20/2023	ABS	AAA	Aaa	AAA	NA	3,122,189.65	0.79%
92867XAB2 VWALT 2019-A A2A	3,648,654.43	USD 03/21/2022	ABS	AAA	NA	AAA	AAA	3,674,445.71	0.94%
CCYUSD Cash	1.69	USD 09/30/2020	CASH	AAA	Aaa	AAA	AAA	1.69	0.00%
CCYUSD Receivable	57.61	USD 09/30/2020	CASH	AAA	Aaa	AAA	AAA	57.61	0.00%
CCYUSD Payable	-1,100,000.00	USD 09/30/2020	CASH	AAA	Aaa	AAA	AAA	-1,100,000.00	-0.28%
--- ---	**85,659,990.45**	**USD 06/28/2021**	---	**AAA**	**Aaa**	**AAA**	**AAA**	**86,524,054.90**	**22.03%**

AA+

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US Dollar

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WC-CalOptima
Account: XXXX2500
Investment Strategy: Short Duration Fixed Income
Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
088006JV4 BEVERLY HILLS CALIF PUB FING AUTH LEASE REV	600,000.00	USD 06/01/2021	MUNI	AA+	NA	AA+	NA	599,964.00	0.15%
13067WQY1 CALIFORNIA ST DEPT WTR RES CENT VY PROJ REV	1,925,000.00	USD 12/01/2021	MUNI	AA+	Aa1	AAA	NA	1,927,092.10	0.49%
677521BD7 OHIO STATE	2,600,000.00	USD 08/01/2021	MUNI	AA+	Aa1	AA+	AA+	2,726,966.67	0.69%
--- ---	**5,125,000.00**	**USD 09/08/2021**	**MUNI**	**AA+**	**Aa1**	**AA+**	**AA+**	**5,254,022.77**	**1.34%**

AA

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
084664BQ3 BERKSHIRE HATHAWAY FINANCE CORP	3,000,000.00	USD 01/15/2021	CORP	AA	Aa2	AA	A+	3,061,622.14	0.78%
13063DWC8 CALIFORNIA ST	3,500,000.00	USD 05/01/2021	MUNI	AA	Aa2	AA-	AA	3,564,901.67	0.91%
13079XBP0 CALIFORNIA STATEWIDE CMNTYS DEV AUTH TRANSN REV CT	500,000.00	USD 06/01/2021	MUNI	AA	NA	AA	NA	499,975.00	0.13%
166756AG1 CHEVRON USA INC	2,000,000.00	USD 08/12/2022	CORP	AA	Aa2	AA	NA	2,000,639.11	0.51%
166764BU3 CHEVRON CORP	2,000,000.00	USD 05/11/2023	CORP	AA	Aa2	AA	NA	2,040,300.78	0.52%
542424WH5 LONG BEACH CALIF HBR REV	2,500,000.00	USD 07/15/2021	MUNI	AA	Aa2	NA	AA	2,596,486.11	0.66%
79771TNS2 SAN FRANCISCO CALIF CITY & CNTY UNI SCH DIST	3,500,000.00	USD 10/01/2020	MUNI	AA	Aa2	NA	NA	3,500,595.00	0.89%
91412HFJ7 UNIVERSITY CALIF REVS	1,500,000.00	USD 05/15/2022	MUNI	AA	Aa2	AA	AA	1,503,806.88	0.38%
931142EJ8 WALMART INC	5,000,000.00	USD 06/23/2021	CORP	AA	Aa2	AA	AA	5,150,994.02	1.31%
--- ---	**23,500,000.00**	**USD 08/11/2021**	---	**AA**	**Aa2**	**AA**	**AA**	**23,919,320.70**	**6.09%**

AA-

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
032556GL0 ANAHEIM CALIF HSG & PUB IMPT AUTH REV	1,000,000.00	USD 10/01/2020	MUNI	AA-	NA	AA-	AA-	1,009,182.75	0.26%

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Credit Rating

US Dollar

As of 30 September 2020

WC-CalOptima
Account: XXXX2500
Investment Strategy: Short Duration Fixed Income
Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
072024WV0 BAY AREA TOLL AUTH CALIF TOLL BRDG REV	4,000,000.00	USD 04/01/2021	MUNI	AA-	A1	AA-	AA-	4,071,180.00	1.04%
09247XAH4 BLACKROCK INC	2,000,000.00	USD 05/24/2021	CORP	AA-	Aa3	AA-	NA	2,081,558.05	0.53%
09247XAH4 BLACKROCK INC	1,050,000.00	USD 05/24/2021	CORP	AA-	Aa3	AA-	NA	1,092,817.98	0.28%
544587X94 LOS ANGELES CALIF MUN IMPT CORP LEASE REV	1,250,000.00	USD 11/01/2021	MUNI	AA-	NA	AA-	NA	1,250,865.80	0.32%
79727LBN8 SAN DIEGO CALIF CONVENTION CTR EXPANSION FING AUTH	500,000.00	USD 04/15/2021	MUNI	AA-	NA	AA-	AA-	502,236.25	0.13%
79727LBP3 SAN DIEGO CALIF CONVENTION CTR EXPANSION FING AUTH	1,000,000.00	USD 04/15/2022	MUNI	AA-	NA	AA-	AA-	1,010,318.33	0.26%
79765R4L0 SAN FRANCISCO CALIF CITY & CNTY PUB UTILS COMMN WT	1,000,000.00	USD 11/01/2021	MUNI	AA-	Aa2	AA-	NA	1,029,395.78	0.26%
84247PLG4 SOUTHERN CALIF PUB PWR AUTH REV	1,000,000.00	USD 07/01/2021	MUNI	AA-	Aa2	NA	AA-	1,049,010.00	0.27%
90331HNP4 US BANK NA	1,000,000.00	USD 04/26/2021	CORP	AA-	A1	AA-	AA-	1,027,605.30	0.26%
90331HPK3 US BANK NA	1,500,000.00	USD 01/21/2022	CORP	AA-	A1	AA-	AA-	1,503,380.35	0.38%
916544EQ8 UPPER SANTA CLARA VY JT PWRS AUTH CALIF REV	2,180,000.00	USD 08/01/2021	MUNI	AA-	NA	AA	AA-	2,182,624.48	0.56%
--- ---	**17,480,000.00**	**USD 07/05/2021**	---	**AA-**	**Aa3**	**AA-**	**AA-**	**17,810,175.07**	**4.53%**

A+

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
17325FAQ1 CITIBANK NA	1,500,000.00	USD 07/23/2021	CORP	A+	Aa3	A+	A+	1,544,234.43	0.39%
22546QAR8 CREDIT SUISSE AG (NEW YORK BRANCH)	2,000,000.00	USD 10/29/2021	CORP	A+	A1	A+	A	2,081,633.33	0.53%
665859AL8 NORTHERN TRUST CORP	5,000,000.00	USD 11/04/2020	CORP	A+	A2	A+	A+	5,084,649.50	1.29%
69371RN85 PACCAR FINANCIAL CORP	750,000.00	USD 11/13/2020	CORP	A+	A1	A+	NA	757,446.37	0.19%
69371RN93 PACCAR FINANCIAL CORP	3,740,000.00	USD 03/01/2021	CORP	A+	A1	A+	NA	3,788,060.28	0.96%

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Credit Rating

US Dollar

As of 30 September 2020

WC-CalOptima
Account: XXXX2500
Investment Strategy: Short Duration Fixed Income
Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
695114CM8 PACIFICORP	3,694,000.00	USD 06/15/2021	CORP	A+	A1	A+	WR	3,795,286.38	0.97%
798736AT1 SAN LUIS UNIT/WESTLANDS WTR DIST FING AUTH CALIF R	1,500,000.00	USD 09/01/2021	MUNI	A+	NA	AA	A+	1,504,885.00	0.38%
857477AG8 STATE STREET CORP	950,000.00	USD 03/07/2021	CORP	A+	A1	A	AA-	970,126.35	0.25%
857477AG8 STATE STREET CORP	1,000,000.00	USD 03/07/2021	CORP	A+	A1	A	AA-	1,021,185.64	0.26%
857477AV5 STATE STREET CORP	825,000.00	USD 05/19/2021	CORP	A+	A1	A	AA-	839,927.16	0.21%
89236TFQ3 TOYOTA MOTOR CREDIT CORP	1,500,000.00	USD 01/08/2021	CORP	A+	A1	A+	A+	1,521,791.80	0.39%
89236TGS8 TOYOTA MOTOR CREDIT CORP	2,250,000.00	USD 08/13/2021	CORP	A+	A1	A+	A+	2,252,670.73	0.57%
91159HHA1 U.S. BANCORP	2,000,000.00	USD 05/24/2021	CORP	A+	A1	A+	A+	2,072,262.75	0.53%
--- ---	**26,709,000.00**	**USD 04/17/2021**	---	**A+**	**A1**	**A+**	**A+**	**27,234,159.73**	**6.93%**

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Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
06051GEE5 BANK OF AMERICA CORP	819,000.00	USD 01/05/2021	CORP	A	A2	A-	A+	842,446.56	0.21%
06051GHH5 BANK OF AMERICA CORP	4,000,000.00	USD 05/17/2022	CORP	A	A2	A-	A+	4,127,088.74	1.05%
14913Q2P3 CATERPILLAR FINANCIAL SERVICES CORP	1,000,000.00	USD 09/07/2021	CORP	A	A3	A	A	1,002,246.69	0.26%
15189XAP3 CENTERPOINT ENERGY HOUSTON ELECTRIC LLC	5,465,000.00	USD 06/01/2021	CORP	A	A2	A	A	5,547,197.68	1.41%
15189XAP3 CENTERPOINT ENERGY HOUSTON ELECTRIC LLC	350,000.00	USD 06/01/2021	CORP	A	A2	A	A	355,264.26	0.09%
24422ESL4 JOHN DEERE CAPITAL CORP	2,000,000.00	USD 03/04/2021	CORP	A	A2	A	A	2,024,677.68	0.52%
24422EUL1 JOHN DEERE CAPITAL CORP	2,000,000.00	USD 10/09/2020	CORP	A	A2	A	A	2,002,147.27	0.51%
24422EUV9 JOHN DEERE CAPITAL CORP	715,000.00	USD 06/07/2021	CORP	A	A2	A	A	729,676.77	0.19%
24422EUV9 JOHN DEERE CAPITAL CORP	1,000,000.00	USD 06/07/2021	CORP	A	A2	A	A	1,020,526.95	0.26%

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WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
341081GA9 FLORIDA POWER & LIGHT CO	3,450,000.00	USD 07/28/2023	CORP	A	A1	A	NA	3,456,321.46	0.88%
369550BF4 GENERAL DYNAMICS CORP	2,250,000.00	USD 05/11/2021	CORP	A	A2	A	WR	2,257,134.53	0.57%
438516CD6 HONEYWELL INTERNATIONAL INC	1,500,000.00	USD 08/19/2022	CORP	A	A2	A	A	1,502,087.98	0.38%
459200KD2 INTERNATIONAL BUSINESS MACHINES CORP	4,260,000.00	USD 05/13/2021	CORP	A	A2	A	WR	4,274,332.71	1.09%
46625HJC5 JPMORGAN CHASE & CO	3,500,000.00	USD 08/15/2021	CORP	A	A2	A-	AA-	3,645,088.63	0.93%
69353REY0 PNC BANK NA	3,470,000.00	USD 12/09/2021	CORP	A	A2	A	A+	3,585,355.58	0.91%
69353REY0 PNC BANK NA	1,250,000.00	USD 12/09/2021	CORP	A	A2	A	A+	1,291,554.60	0.33%
76913CAV1 RIVERSIDE CNTY CALIF PENSION OBLIG	3,500,000.00	USD 02/15/2021	MUNI	A	A2	AA	NA	3,529,947.36	0.90%
86787EBE6 TRUIST BANK	4,300,000.00	USD 05/17/2022	CORP	A	A2	A	A+	4,511,367.54	1.15%
91324PBV3 UNITEDHEALTH GROUP INC	3,000,000.00	USD 03/15/2022	CORP	A	A3	A+	A	3,094,790.81	0.79%
91324PDG4 UNITEDHEALTH GROUP INC	1,500,000.00	USD 06/15/2021	CORP	A	A3	A+	A	1,502,707.99	0.38%
--- ---	**49,329,000.00**	**USD 10/25/2021**	---	**A**	**A2**	**A**	**A+**	**50,301,961.80**	**12.81%**

A-

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
172967KB6 CITIGROUP INC	4,000,000.00	USD 10/26/2020	CORP	A-	A3	BBB+	A	4,052,028.37	1.03%
31677QBG3 FIFTH THIRD BANK NA (OHIO)	1,850,000.00	USD 06/14/2021	CORP	A-	A3	A-	A-	1,884,808.06	0.48%
31677QBG3 FIFTH THIRD BANK NA (OHIO)	4,000,000.00	USD 06/14/2021	CORP	A-	A3	A-	A-	4,075,260.68	1.04%
38143U8G9 GOLDMAN SACHS GROUP INC	3,000,000.00	USD 02/25/2021	CORP	A-	A3	BBB+	A	3,027,061.53	0.77%
44644AAD9 HUNTINGTON NATIONAL BANK	1,500,000.00	USD 05/14/2021	CORP	A-	A3	A-	A-	1,542,214.45	0.39%
61746BEB8 MORGAN STANLEY	1,400,000.00	USD 04/21/2021	CORP	A-	A3	BBB+	A	1,414,442.95	0.36%
911312BH8 UNITED PARCEL SERVICE INC	2,800,000.00	USD 04/01/2021	CORP	A-	A2	A-	NA	2,804,233.10	0.71%

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WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
--- ---	18,550,000.00	USD 03/21/2021	CORP	A-	A3	A-	A	18,800,049.14	4.79%

A-1+

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
30229ALP2 Exxon Mobil Corporation	4,000,000.00	USD 11/23/2020	CP	A-1+	P-1	A-1+	NA	3,999,352.00	1.02%
313312J27 FEDERAL FARM CREDIT BANKS FUNDING CORP	10,000,000.00	USD 10/02/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	9,999,983.30	2.55%
313312K66 FEDERAL FARM CREDIT BANKS FUNDING CORP	5,000,000.00	USD 10/14/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	4,999,891.65	1.27%
313312K66 FEDERAL FARM CREDIT BANKS FUNDING CORP	20,000,000.00	USD 10/14/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	19,999,566.60	5.09%
313312L73 FEDERAL FARM CREDIT BANKS FUNDING CORP	20,000,000.00	USD 10/23/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	19,999,266.60	5.09%
313312M56 FEDERAL FARM CREDIT BANKS FUNDING CORP	10,000,000.00	USD 10/29/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	9,999,533.30	2.55%
313312N30 FEDERAL FARM CREDIT BANKS FUNDING CORP	2,000,000.00	USD 11/04/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	1,999,867.78	0.51%
313312P79 FEDERAL FARM CREDIT BANKS FUNDING CORP	5,000,000.00	USD 11/16/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	4,999,552.80	1.27%
313312T42 FEDERAL FARM CREDIT BANKS FUNDING CORP	10,000,000.00	USD 12/15/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	9,998,125.00	2.55%
313313AN8 FEDERAL FARM CREDIT BANKS FUNDING CORP	5,000,000.00	USD 01/13/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	4,998,700.00	1.27%
313313CN6 FEDERAL FARM CREDIT BANKS FUNDING CORP	5,000,000.00	USD 03/02/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	4,997,888.90	1.27%
313313DN5 FEDERAL FARM CREDIT BANKS FUNDING CORP	14,000,000.00	USD 03/26/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	13,993,155.54	3.56%
313313DU9 FEDERAL FARM CREDIT BANKS FUNDING CORP	2,000,000.00	USD 04/01/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	1,998,988.88	0.51%
313313DY1 FEDERAL FARM CREDIT BANKS FUNDING CORP	2,000,000.00	USD 04/05/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	1,998,966.66	0.51%
313313FS2 FEDERAL FARM CREDIT BANKS FUNDING CORP	750,000.00	USD 05/17/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	749,477.50	0.19%
313385AN6 FEDERAL HOME LOAN BANKS	10,000,000.00	USD 01/13/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	9,997,400.00	2.55%
313385EA0 FEDERAL HOME LOAN BANKS	3,000,000.00	USD 04/07/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	2,998,433.34	0.76%
313385EQ5 FEDERAL HOME LOAN BANKS	5,000,000.00	USD 04/21/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	4,997,194.45	1.27%

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WELLS FARGO Asset Management

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
313385ER3 FEDERAL HOME LOAN BANKS	5,000,000.00	USD 04/22/2021	AGCY DISC	A-1+	P-1	A-1+	F1+	4,997,180.55	1.27%
313396L35 FEDERAL HOME LOAN MORTGAGE CORP	10,000,000.00	USD 10/19/2020	AGCY DISC	A-1+	P-1	A-1+	F1+	9,999,700.00	2.55%
9127962Q1 UNITED STATES TREASURY	2,500,000.00	USD 04/22/2021	T-BILL	A-1+	P-1	A-1+	F1+	2,498,450.00	0.64%
9127964H9 UNITED STATES TREASURY	3,700,000.00	USD 10/13/2020	T-BILL	A-1+	P-1	A-1+	F1+	3,699,907.50	0.94%
--- ---	**153,950,000.00**	**USD 12/14/2020**	---	**A-1+**	**P-1**	**A-1+**	**AAA**	**153,920,582.35**	**39.19%**

A-1

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
38346LK21 Gotham Funding Corporation	9,000,000.00	USD 10/02/2020	CP	A-1	P-1	A-1	F1	8,999,939.97	2.29%
38346LK21 Gotham Funding Corporation	**9,000,000.00**	**USD 10/02/2020**	**CP**	**A-1**	**P-1**	**A-1**	**F1**	**8,999,939.97**	**2.29%**

Summary

Identifier, Description	Ending Base Current Units	Currency, Ending Final Maturity	Security Type	Rating	Moody's	S&P	Fitch	Base Market Value + Accrued	% of Base Market Value + Accrued
--- ---	**389,302,990.45**	**USD 04/15/2021**	---	**AA**	**Aa1**	**AA**	**AA+**	**392,764,266.42**	**100.00%**

* Grouped by: Rating. * Groups Sorted by: Rating. * Weighted by: Base Market Value + Accrued.

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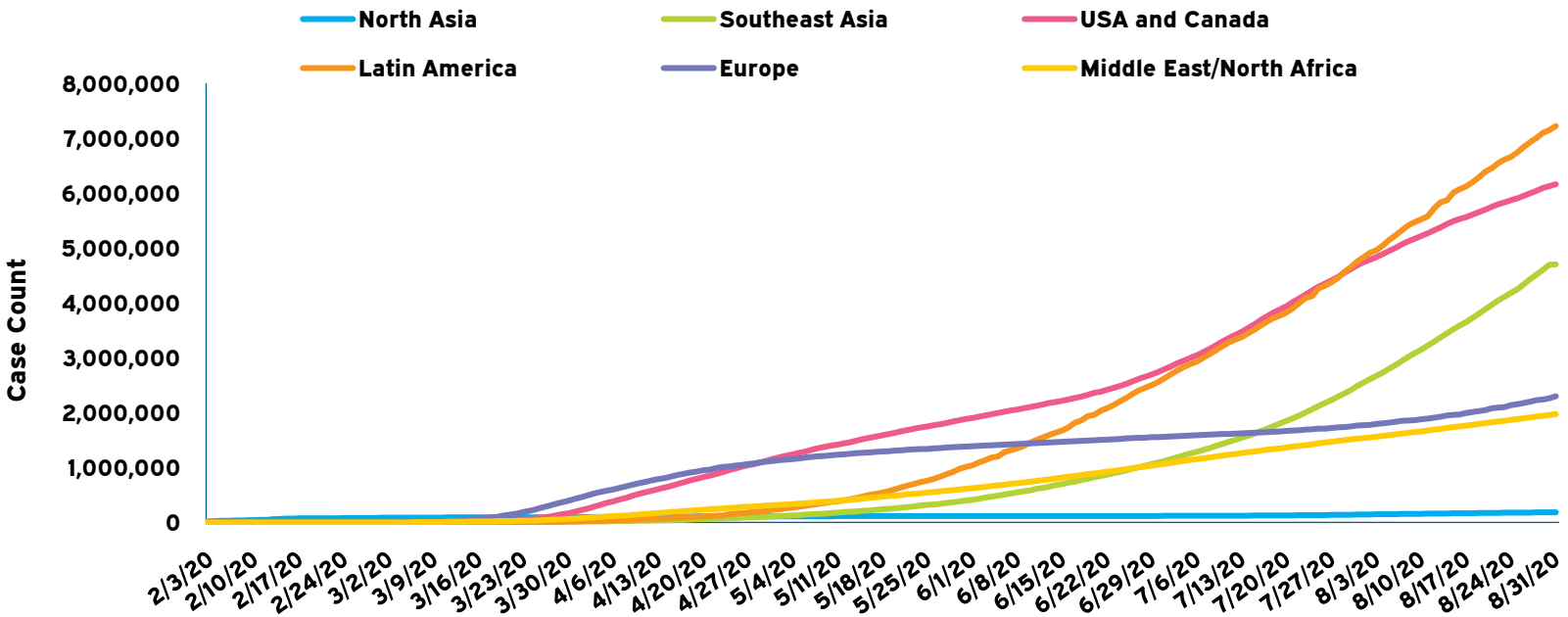
Economic and Market Update

Data as of August 31, 2020



Case Count by Select Region[1,2]

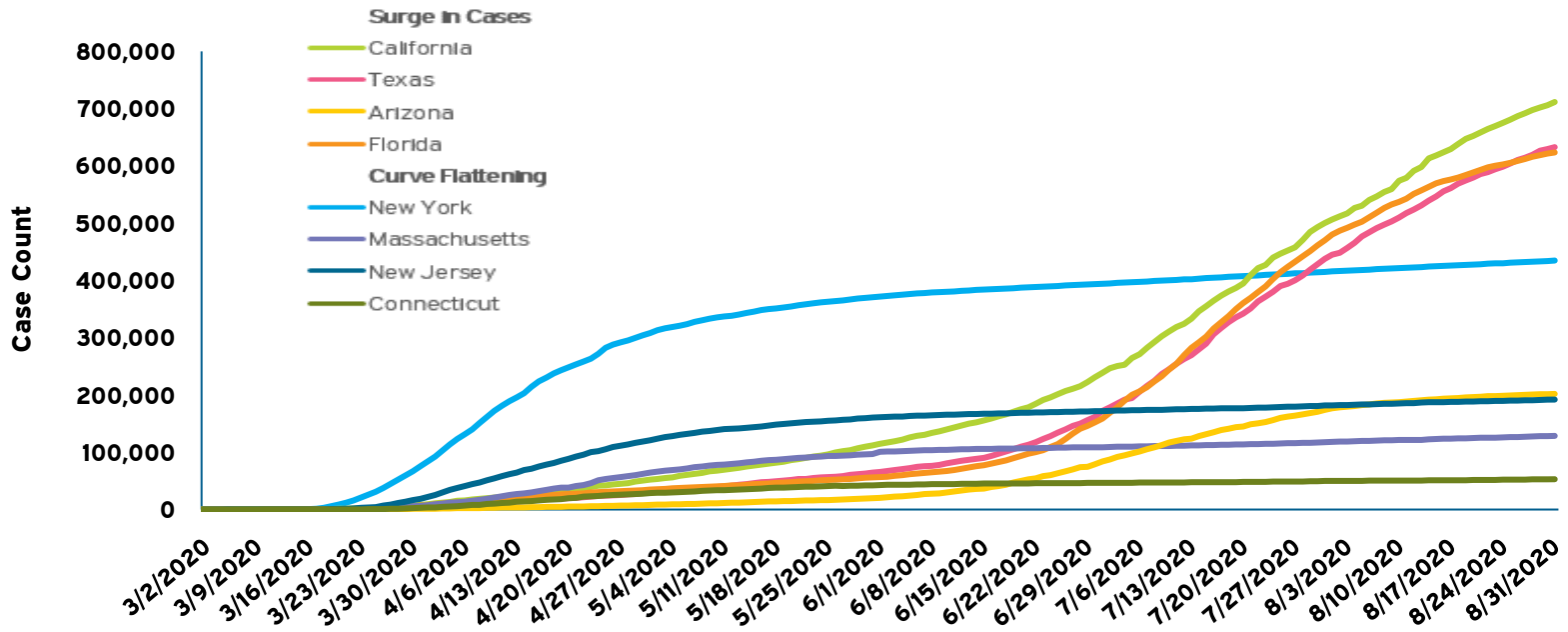


- Cases of COVID-19 continue to grow globally with now over 28 million reported cases across 188 countries.
- The US remains the country with the highest cases, while cases in Latin America are surging, driven by Brazil. India has also emerged as a hotspot with the second most cases globally.

[1] Source: Bloomberg. Data is as of August 31, 2020.

[2] North Asia: China, Hong Kong, Japan, South Korea, and Taiwan. Southeast Asia: Singapore, India, Indonesia, Malaysia, Pakistan, Philippines, Thailand, Bangladesh, Sri Lanka, and Vietnam. Europe: Austria, Belarus, Bulgaria, Croatia, Czech Republic, Denmark, France, Germany, Hungary, Italy, Netherlands, Norway, Poland, Romania, Spain, Sweden, United Kingdom, Switzerland, and Ukraine. Latin America: Chile, Brazil, Mexico, Argentina, Colombia, Peru, Venezuela, Ecuador, Panama, Paraguay, Costa Rica, Bolivia, Uruguay, El Salvador, Honduras, Cuba, Dominican Republic, Haiti, and Nicaragua. Middle East/North Africa: Algeria, Bahrain, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, Syria, Turkey, Tunisia, United Arab Emirates, and Yemen.

COVID-19 Cases by State[1]



- There has been some improvement in cases in states that experienced spikes as they reopened, but they are not out of the woods yet.
- Some states that were hardest hit in the early stages made progress on containing the virus, but have also seen small upticks in cases.
- As we move into the colder months, flu season and the reopening of schools in some areas could create additional stresses on the healthcare system.

[1] Source: Bloomberg. Data is as of August 31, 2020.

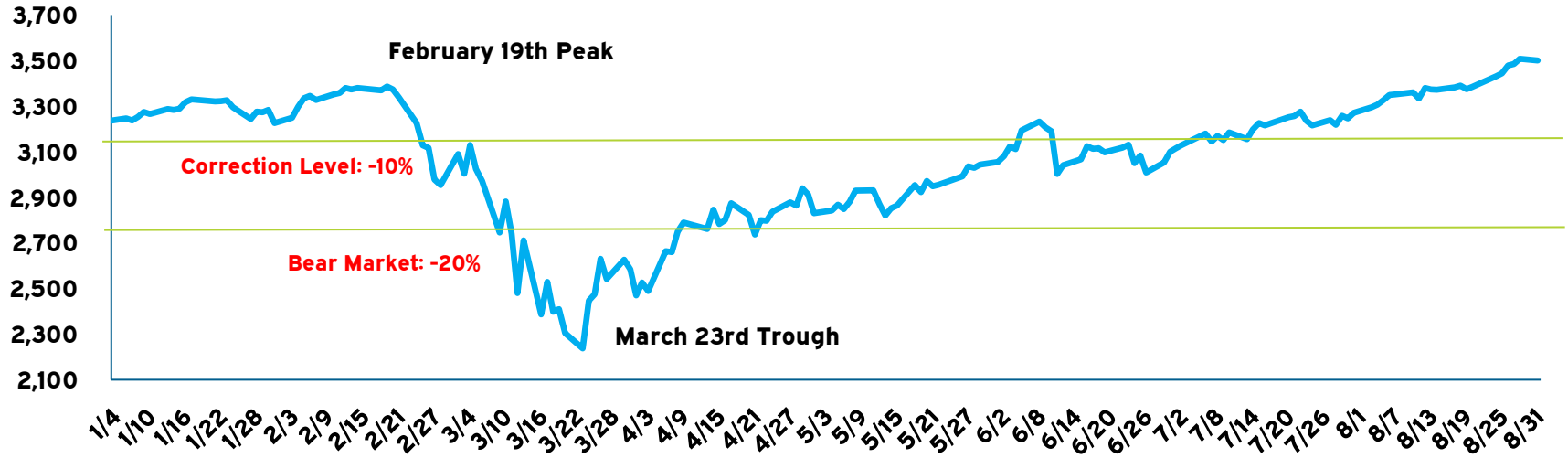
Market Returns[1]

Indices	August	YTD	1 Year	3 Year	5 Year	10 Year
S&P 500	7.2%	9.7%	21.9%	14.5%	14.5%	15.2%
MSCI EAFE	5.1%	-4.6%	6.4%	2.3%	4.7%	5.9%
MSCI Emerging Markets	2.2%	0.4%	14.5%	2.8%	8.7%	3.8%
MSCI China	5.7%	19.7%	36.8%	9.2%	13.7%	7.8%
Bloomberg Barclays Aggregate	-0.8%	6.9%	6.5%	5.1%	4.3%	3.7%
Bloomberg Barclays TIPS	1.1%	9.6%	9.0%	5.7%	4.6%	3.7%
Bloomberg Barclays High Yield	1.0%	1.7%	4.7%	4.9%	6.5%	6.9%
10-year US Treasury	-1.3%	12.5%	8.6%	6.5%	4.4%	4.3%
30-year US Treasury	-6.1%	23.8%	13.6%	12.3%	8.1%	8.1%

- Global risk assets have recovered meaningfully from their lows, largely driven by record fiscal and monetary policy stimulus; the S&P 500 appreciated by over 56% from the mid-March lows.
- Risk assets have reacted positively to the combination of a gradual re-opening of the global economy, some economic data beating expectations, and the potential for a vaccine being developed sooner than initially expected.
- Despite the recovery in risk assets, yields on safe-haven assets like US Treasuries remain at record lows due to expectations for extremely accommodative monetary policy for the foreseeable future and expectations for relatively weak economic growth.

[1] Source: InvestorForce and Bloomberg. Data is as of August 31, 2020.

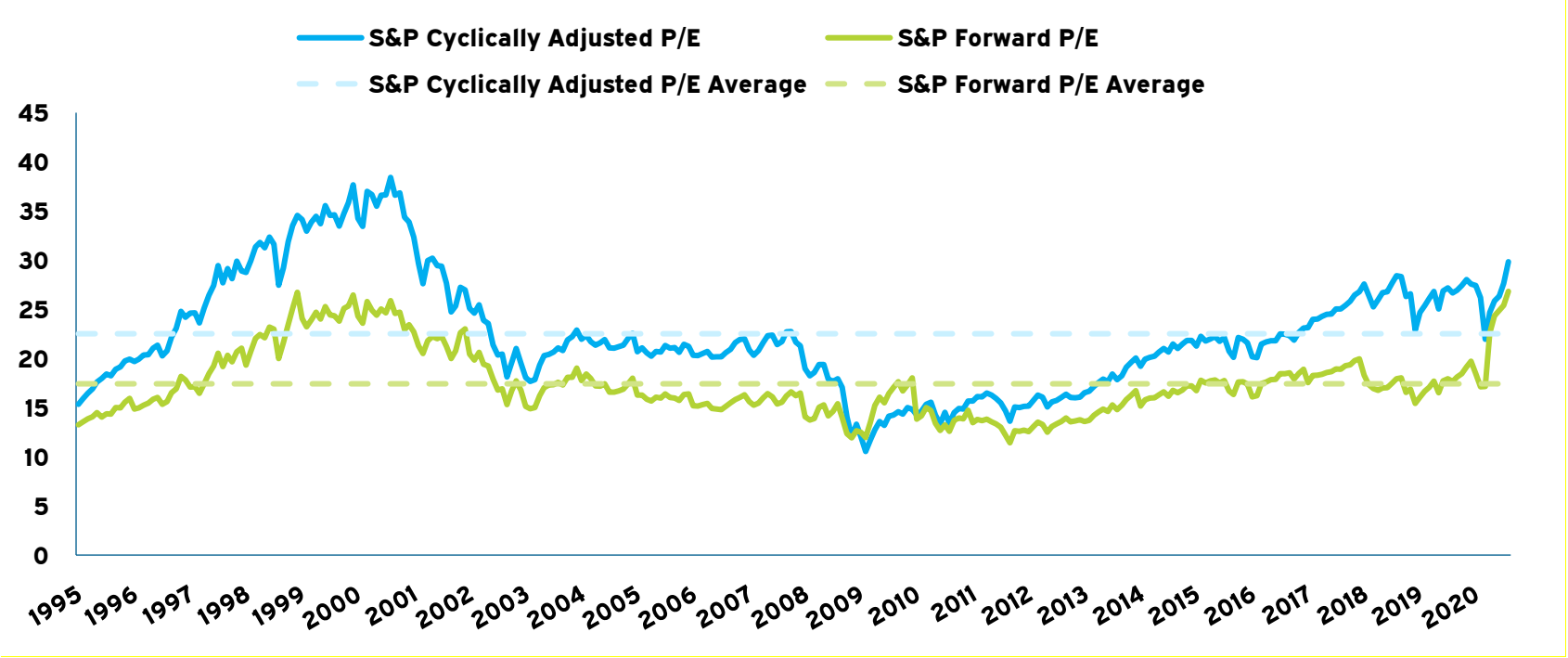
S&P 500 Fully Recovers[1]



- Given the anticipated economic carnage surrounding the pandemic, US stocks declined from a February peak into bear market (-20%) territory at the fastest pace in history.
- From the February 19 peak, the S&P 500 plunged 34% in just 24 trading days.
- The index rebounded quickly from its lows and finished above its pre-COVID levels at the end of August, with year-to-date gains of close to 10%. The largest drivers of the unprecedented recovery include the significant monetary and fiscal stimulus in the US, as well as improvements in parts of the economy as it slowly reopens.
- It is unclear whether the pace of the recovery is sustainable in light of the recent surge in cases, as well as risks such as the looming US election, ongoing trade tensions between the US and China, and continued uncertainty regarding the next round of US fiscal stimulus.

[1] Source: Bloomberg. Data is as of August 31, 2020.

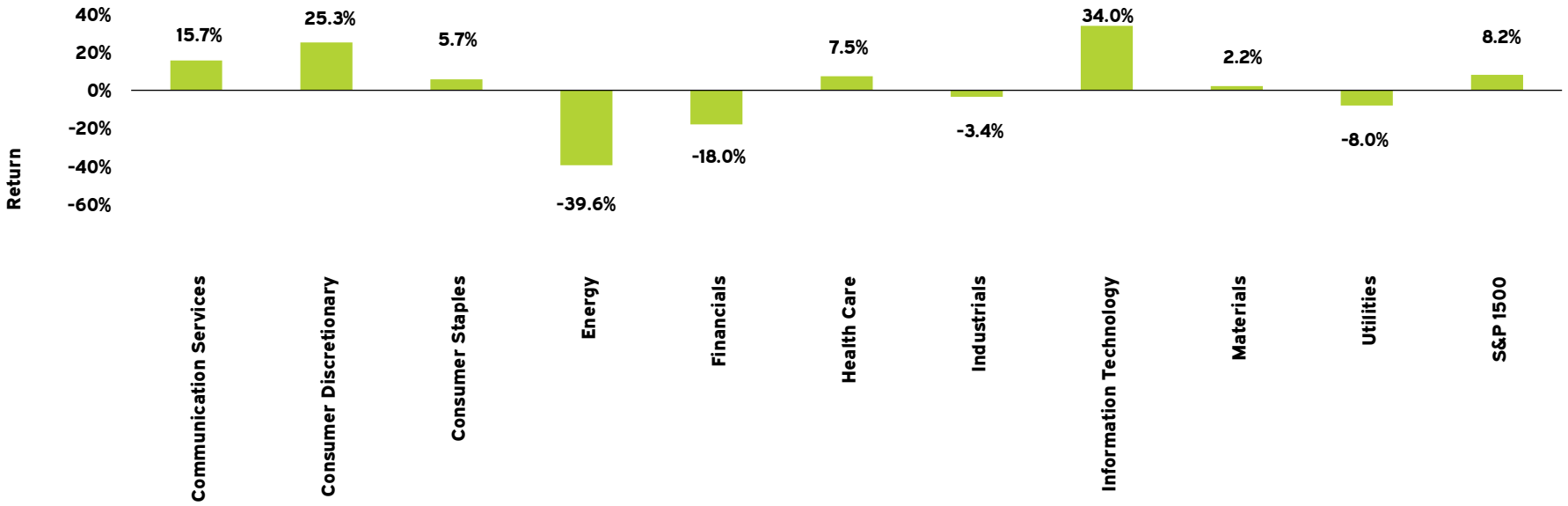
S&P Equity Valuations[1]



- As US equity markets continue to rise, valuations based on both forward- and backward-looking earnings have become even more stretched.
- Many are looking to improvements in earnings to support market levels as the US economy continues to reopen, with historically low interest rates also providing support.
- The key risk remains that a spike in COVID-19 cases could slow, or reverse, reopening plans.

[1] Source: Bloomberg. Data is as of August 31, 2020.

2020 YTD Sector Returns[1]

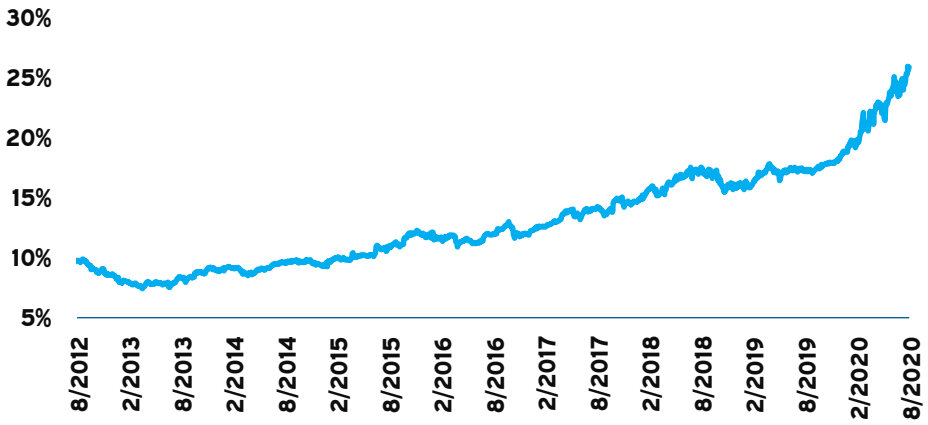


- Information technology remains the best performing sector, with a narrow group of companies including Amazon and Netflix driving market gains. The outperformance has been due to consumers moving to online purchases and entertainment.
- The consumer discretionary sector has also experienced gains as the economy reopens, people return to work, and as stimulus checks were spent.
- The energy sector has seen some improvements given supply cuts and economies starting to reopen, but it remains the sector with the greatest 2020 decline, triggered by the plunge in oil prices. Financials have also struggled in the low interest rate and slow growth environment.

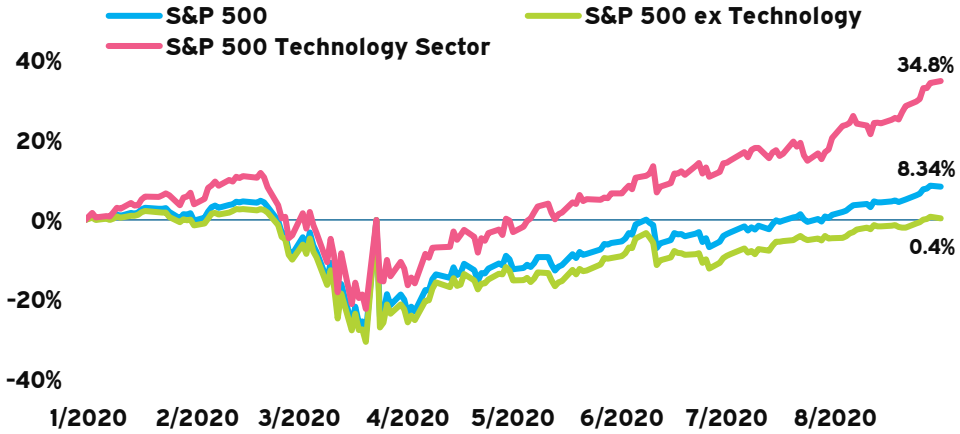
[1] Source: Bloomberg. Data is as of August 31, 2020.

Technology has led the way in the Rebound

FAANG+M Share of S&P 500[1]



Returns Year to Date through August 31[2]



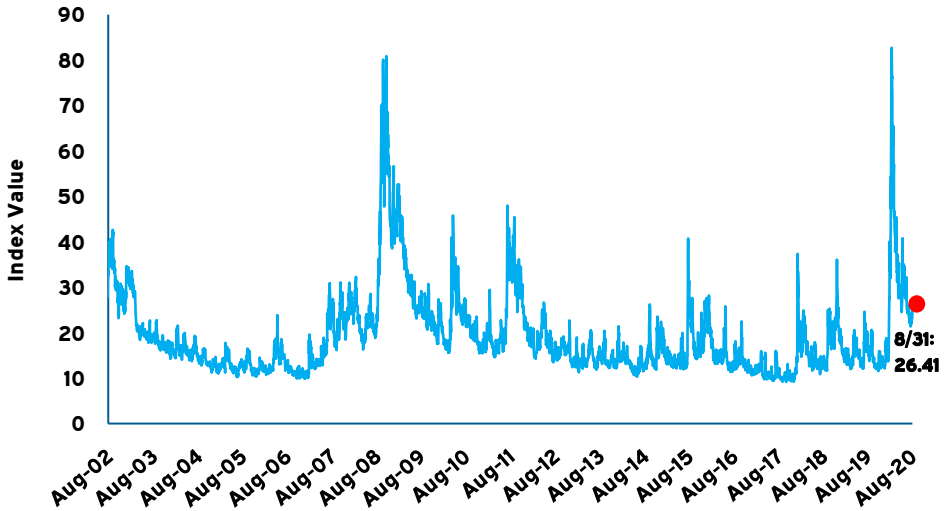
- The recent market recovery has largely been driven by a few select technology companies that benefited from the stay-at-home environment related to the virus.
- Year-to-date, the S&P 500 technology sector returned 34.8% compared to 0.4% for the S&P 500 ex. technology index, with Amazon (+87%), Netflix (+64%), and Apple (+76%) posting strong results.
- The strong relative results of these companies has led to them comprising a growing portion (25.9%) of the S&P 500, which makes their future performance particularly impactful.

[1] FAANG+M = Facebook, Amazon, Apple, Netflix, Google (Alphabet), and Microsoft. The percentage represents the aggregate market capitalization of the 6 companies compared to the total market capitalization of the S&P 500 as of August 31, 2020.

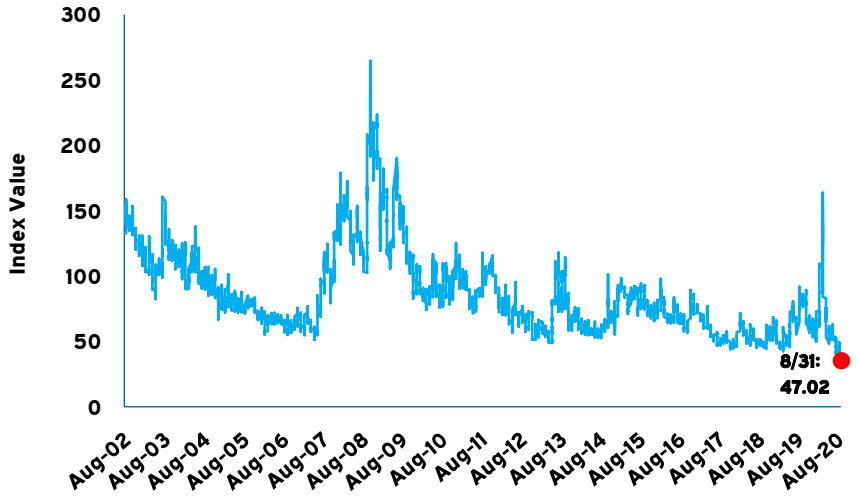
[2] Each data point represents the price change relative to the 12/31/2019 starting value.

Volatility has Declined

VIX Index[1]



MOVE Index[2]



- Expectations of short-term equity volatility, as measured by the VIX index, continued to decline from record levels, though it remains elevated relative to the past decade.
- At the recent height, the VIX reached 82.7, surpassing the pinnacle of volatility during the GFC, showing the magnitude of the crisis, and of investor fear.
- Expectations of volatility within fixed income, as represented by the MOVE index, spiked and then returned to historic lows, helped by the broad level of monetary support and forward guidance by the Fed.

[1] Source: Chicago Board of Exchange. Data is as of August 31, 2020.

[2] Source: Bloomberg. Data is as of August 31, 2020.

Global Financial Crisis Comparison

	2007-2009 Global Financial Crisis	COVID-19 Crisis
Primary Causes	Excess Risk Taking Due to: • Deregulation, un-constrained securitization, shadow banking system, fraud	Pandemic/Natural Disaster: • Large scale global restrictions on businesses and individuals leading to immediate and significant deterioration in economic fundamentals

	2007-2009 Global Financial Crisis	COVID-19 Crisis
Fiscal Measures	• American Recovery Reinvestment Act of 2009: $787 billion • Economic Stimulus Act of 2008: $152 billion	• PPP Act: $659 billion • CARES Act of 2020: $2.3 trillion • Families First Coronavirus Response Act: $150 billion • Coronavirus Preparedness & Response Supplemental Appropriations Act 2020: $8.3 billion • National Emergency: $50 billion

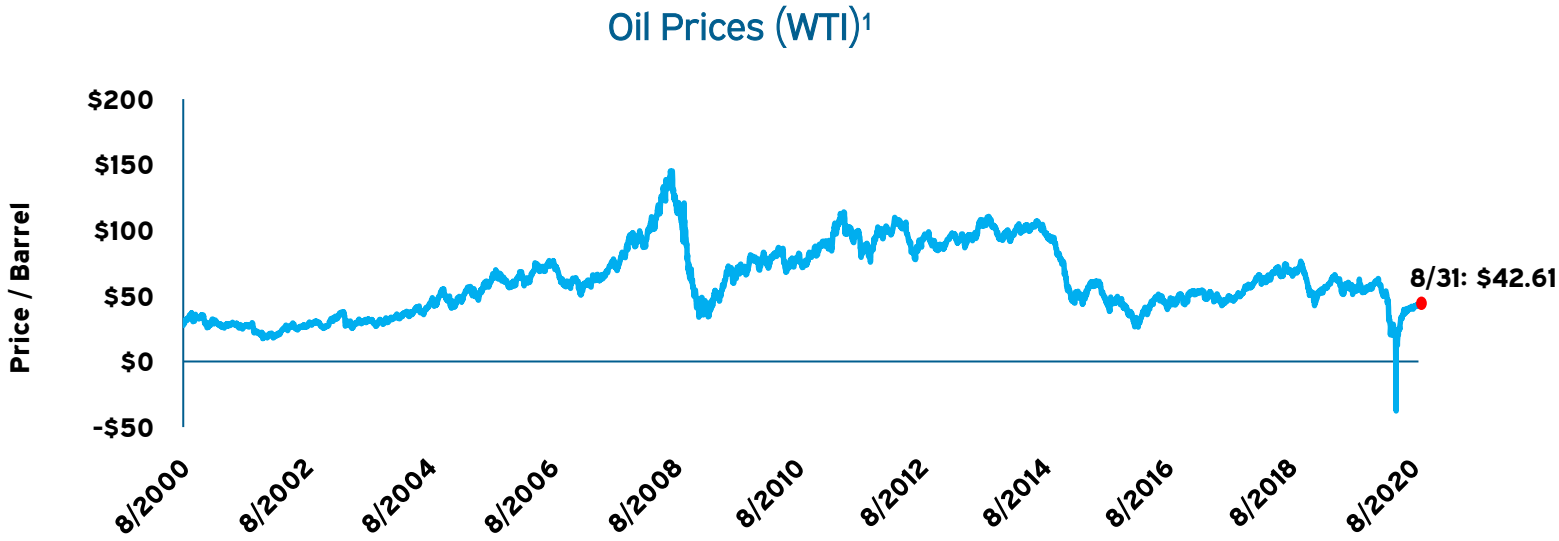
	2007-2009 Global Financial Crisis	COVID-19 Crisis
Monetary Measures		
Lowering Fed Funds Rate	X	X
Quantitative Easing	X	X
Primary Dealer Repos	X	X
Central Bank Swap Lines	X	X
Commercial Paper Funding Facility	X	X
Primary Dealers Credit Facility	X	X
Money Market Lending Facility	X	X
Term Auction Facility	X	
TALF	X	X
TSLF	X	
FIMA Repo Facility		X
Primary & Secondary Corp. Debt		X
PPP Term Facility		X
Municipal Liquidity Facility		X
Main Street Loan Facility		X

Global Financial Crisis Comparison (continued)

- The US **fiscal** response to the COVID-19 Crisis has been materially larger than the response to the 2007-2009 Global Financial Crisis (GFC), and stimulus is acutely focused on areas of the economy showing the greatest need, including small and mid-sized companies. For example, the Paycheck Protection Program (PPP) helps small businesses keep employees working by offering forgivable loans to cover salaries.
- Gridlock continues related to the fifth fiscal package with key issues being discussed/debated including payroll tax cuts, another round of stimulus checks, additional unemployment benefits, and state and local aid. The end to enhanced unemployment benefits in July from the prior stimulus has been particularly impactful to those without jobs.
- On the **monetary** side, markets targeted during both crises represent those most in need, but for the COVID-19 Crisis the policy response was dramatically faster, measured in weeks, not years, as in the GFC.
- Of the monetary stimulus measures, the corporate debt (Primary & Secondary Corporate Debt) programs and Main Street Loan Facility are new and garnered much attention from market participants.
- Through the end of August, Fed programs have experienced various degrees of usage. However, at this point, none has come close to reaching program limits. Still, programs have been extended through December 2020, and the psychological value of knowing the programs are available, if necessary, likely supports market sentiment.

Policy Responses

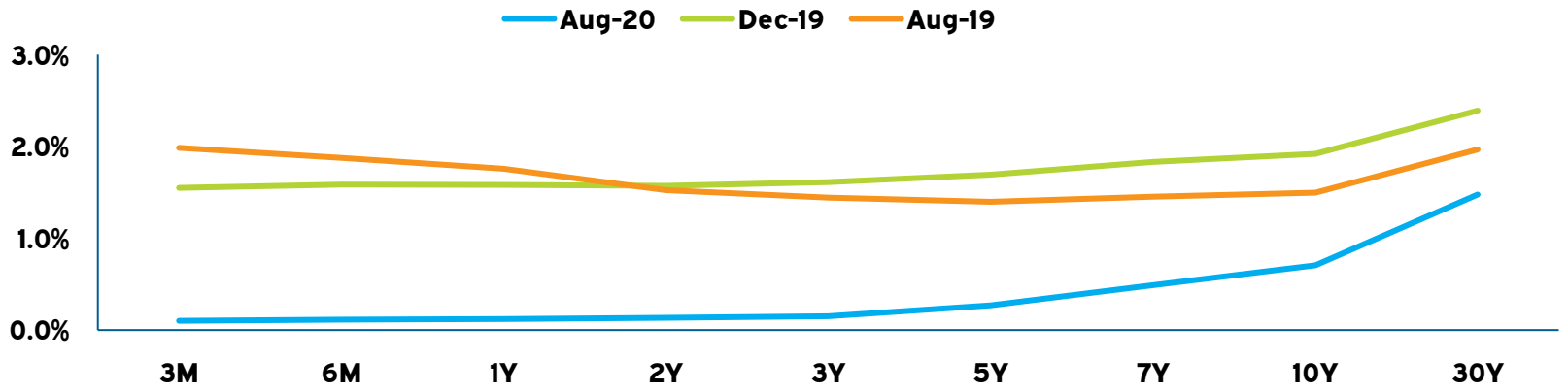
	Fiscal	Monetary
United States	$50 billion to states for virus related support, interest waived on student loans, flexibility on tax payments and filings, expanded COVID-19 testing, paid sick leave for hourly workers, $2 trillion package for individuals, businesses, and state/local governments. Additional $484 billion package to replenish small business loans, provide funding to hospitals, and increase testing.	Cut policy rates to zero, forward guidance suggesting aggressively accommodative policy for the foreseeable future, unlimited QE4, offering trillions in repo market funding, restarted and extended CPFF, PDCF, MMMF programs to support lending and financing markets, expanded US dollar swap lines with foreign central banks, announced IG corporate debt buying program with subsequent amendment for certain HY securities, Main Street Lending program, Muni liquidity facility, repo facility with foreign central banks, and easing of some financial regulations for lenders.
Euro Area	European Union: Shared 750 billion euro stimulus package. Germany: 220 billion euro stimulus France: 57 billion euro stimulus. Italy: 75 billion euro stimulus. Spain: 200 billion euro and 700 million euro loan and aid package, respectively.	Targeted longer-term refinancing operations aimed at small and medium sized businesses, under more favorable pricing, and announced the 750 billion euro Pandemic Emergency Purchase Program, and then expanded the purchases to include lower-quality corporate debt.
Japan	Hundreds of trillions in yen stimulus for citizens and businesses, including low interest loans, deferrals on taxes, and direct cash handouts.	Initially increased QE purchases (ETFs, corporate bonds, and CP) and then expanded to unlimited purchases and doubling of corporate debt and commercial paper, expanded collateral and liquidity requirements, and 0% interest loans to businesses hurt by virus.
China	Tax cuts, low-interest business loans, extra payments to gov't benefit recipients.	Expanded repo facility, policy rate cuts, lowered reserve requirements, loan-purchase scheme.
Canada	$7.1 billion in loans to businesses to help with virus damage, C$381 billion stimulus.	Cut policy rates, expanded bond-buying and repos, lowered bank reserve requirements.
UK (BOE)	190 billion pound stimulus, Tax cut for retailers, small business cash grants, benefits for those infected with virus, expanded access to gov't benefits for self and un-employed.	Lowered policy rates and capital requirements for UK banks, restarts QE program and subsequently increased the purchase amounts.
Australia	$11.4 billion, subsidies for impacted industries like tourism, one-time payment to gov't benefit recipients.	Policy rate cut, started QE.



- Global oil markets rallied from April lows, including from the technically-induced negative levels that saw the May futures contract trade at nearly -$40 per barrel.
- In August, OPEC+ began to relax its 9.7 million barrels/day production cuts (~10% of global output) resulting in an increase of supply by close to 1 million barrels/day. Going forward, they are looking to further reduce cuts to 7.7 million barrels/day.
- Counterbalancing the OPEC+ production cut agreement, US oil producers (particularly shale output) are reportedly turning wells back on as the price of oil rises.
- As OPEC+ starts rolling back production cuts, and the virus spread increases with the potential to weigh on demand, oil prices could experience downward pressure going forward.

[1] Source: Bloomberg. Represents WTI first available futures contract. Data is as of August 31, 2020.

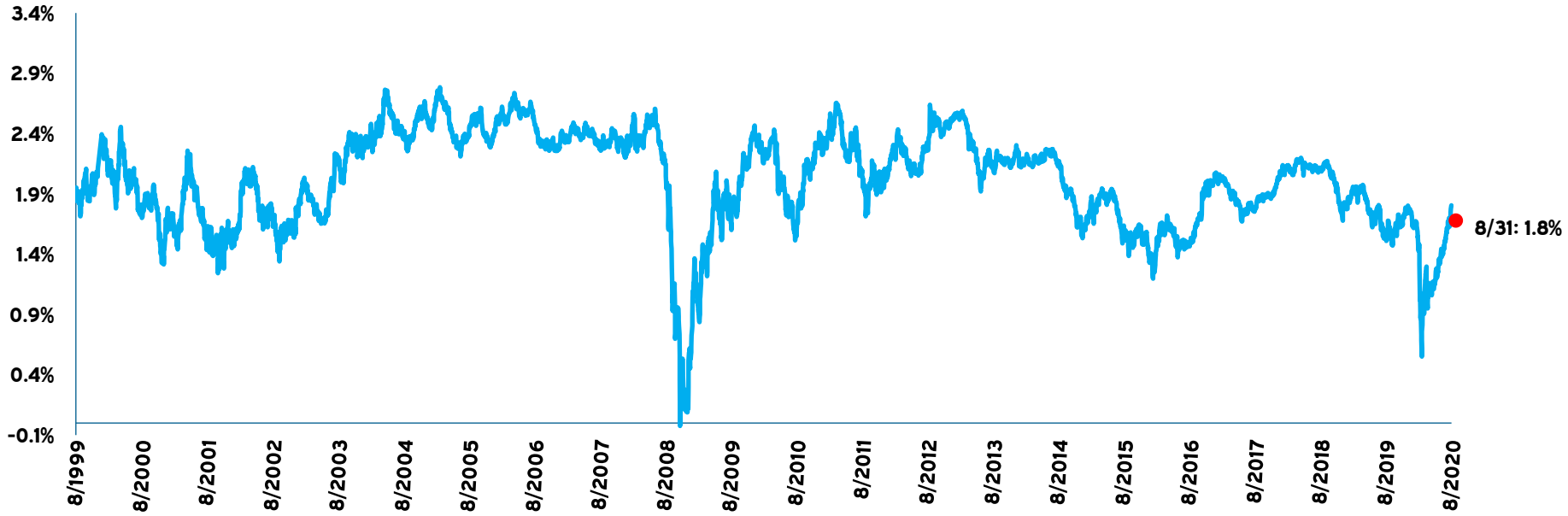
US Yield Curve Declines[1]



- The US Treasury yield curve has declined materially since 2019.
- Cuts in monetary policy rates, and policy makers' open commitments to keep rates low for the foreseeable future, drove yields down in shorter maturities, while flight-to-quality flows, low inflation, and economic growth uncertainty have driven the changes in longer maturities.
- The Federal Reserve's unlimited quantitative easing purchase program has produced further downward pressure on interest rates, particularly in the short- and medium-term sectors due to the purchases being focused on those segments.
- Longer dated bonds have recently experienced some pressure as economic data has slowly improved, but more importantly as the Federal Reserve announced its plan to target an average inflation rate.

[1] Source: Bloomberg. Data is as of August 31, 2020.

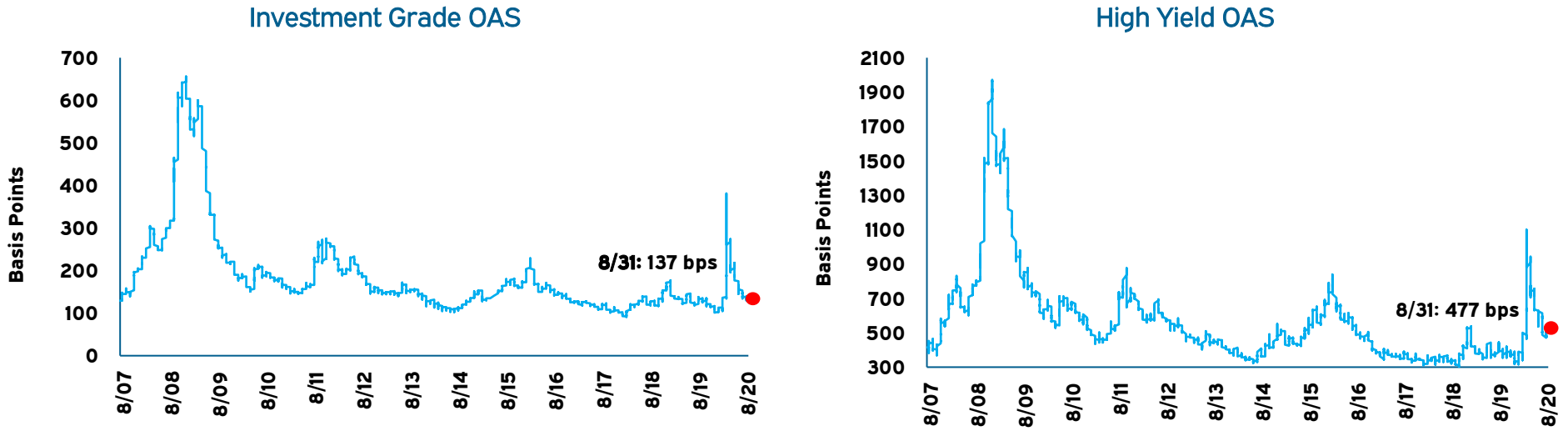
10-Year Breakeven Inflation[1]



- Inflation breakeven rates initially declined sharply, due to a combination of lower growth and inflation expectations, as well as liquidity dynamics in TIPS during the height of rate volatility.
- Liquidity eventually improved and breakeven rates increased as deflationary concerns moderated, but given the uncertainty regarding economic growth and the inflationary effects of the unprecedented US fiscal response, inflation expectations continue to remain below historical averages.

[1] Source: Bloomberg. Data is as of August 31, 2020.

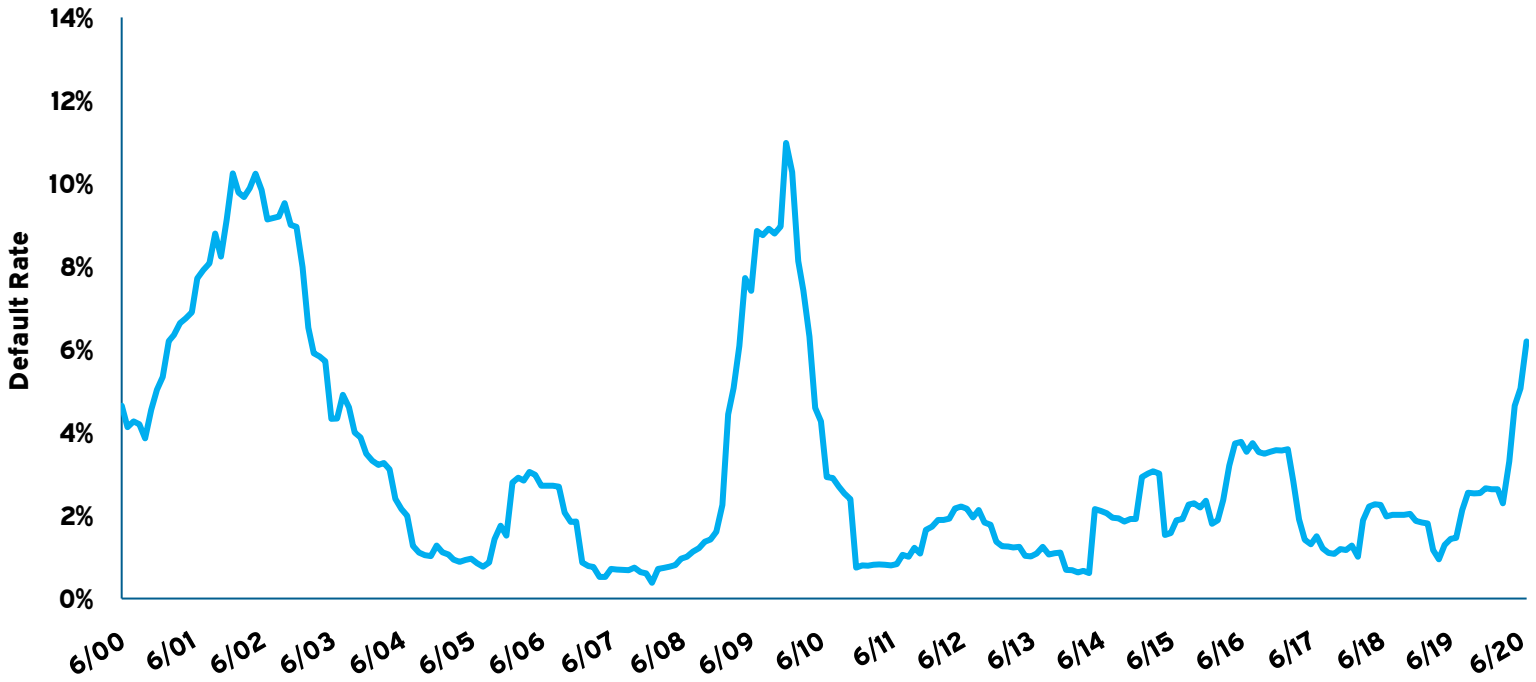
Credit Spreads (High Yield & Investment Grade)[1]



- Credit spreads (the spread above a comparable Treasury bond) for investment grade and high yield corporate debt expanded sharply as investors sought safety.
- Investment grade bonds held up better than high yield bonds. The Federal Reserve's corporate debt purchase program for investment grade and certain high yield securities recently downgraded from investment grade, was well received by investors, leading to a decline in spreads to around long-term averages.
- Overall, corporate debt issuance has more than doubled since 2008, which magnifies the impact of deterioration in the corporate debt market. This is particularly true in the energy sector, which represents over 10% of the high yield bond market.

[1] Source: Federal Reserve Bank of St. Louis Economic Research. Data is as of August 31, 2020.

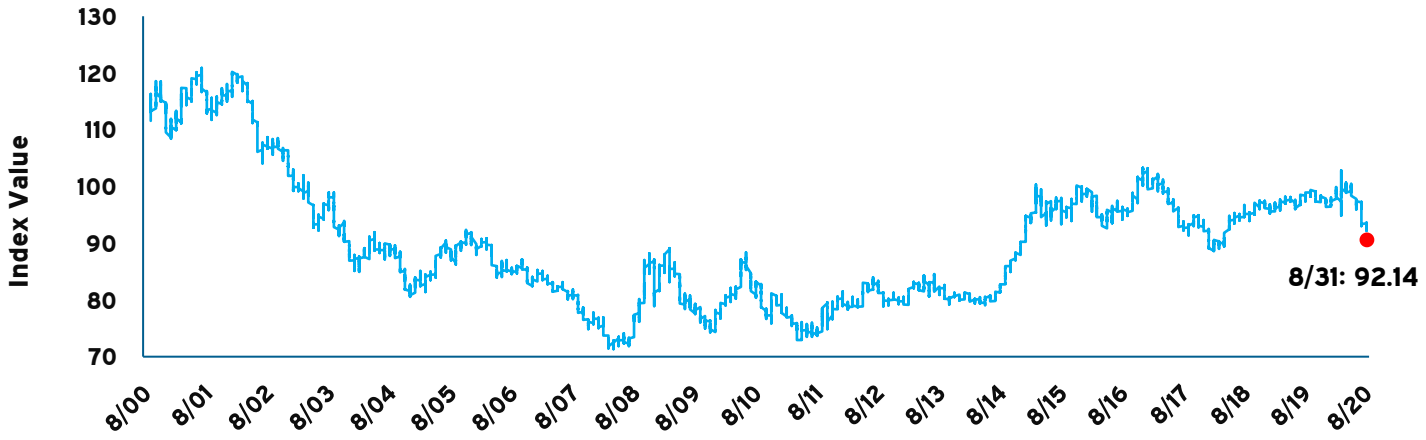
US High Yield Credit Defaults[1]



- Even though spreads have declined, helped by the Federal Reserve's support, defaults, particularly in the high yield sector, have increased dramatically in 2020.
- The energy sector has seen the greatest impact given the decline in oil prices, with defaults reaching double-digit levels and expectations for them to increase.

[1] Source: J.P. Morgan; S&P LCD. July and August data is not yet available. Data is as of June 30, 2020.

US Dollar versus Broad Currencies[1]



- When financial markets began aggressively reacting to COVID-19 developments, the US dollar came under selling pressure as investors sought safe-haven exposure in currencies like the Japanese yen given its current account surplus and its status as the largest creditor globally.
- As the crisis grew into a pandemic, investors' preferences shifted to holding US dollars and highly liquid, short-term securities like US Treasury bills. This global demand for US dollars led to appreciation versus most major currencies.
- To help ease global demand for US dollars, the Federal Reserve, working with a number of global central banks, re-established the US dollar swap program, providing some relief to other currencies. Usage of the program continues to decline as dollar funding demands have eased.
- Recently we have seen some weakness in the dollar as interest rates declined and the US struggled with containing the virus. This has created pressures on already stressed export-focused countries.
- Going forward, the dollar's safe haven quality and the relatively higher rates in the US could provide support.

[1] Source: Bloomberg. Represents the DXY Index. Data is as of August 31, 2020.

Economic Impact

Supply Chain Disruptions:

- Factories closing, increased cost of stagnant inventory, and disrupted supply agreements.
- Reduced travel, tourism, and separation policies including closed borders: Significant impact on service-based economies.

Labor Force Impacts:

- Huge layoffs across service and manufacturing economies.
- Increased strains as workforce productivity declines from increased societal responsibilities (e.g., home schooling of children) and lower functionality working from home.
- Illnesses from the disease will also depress the labor force.

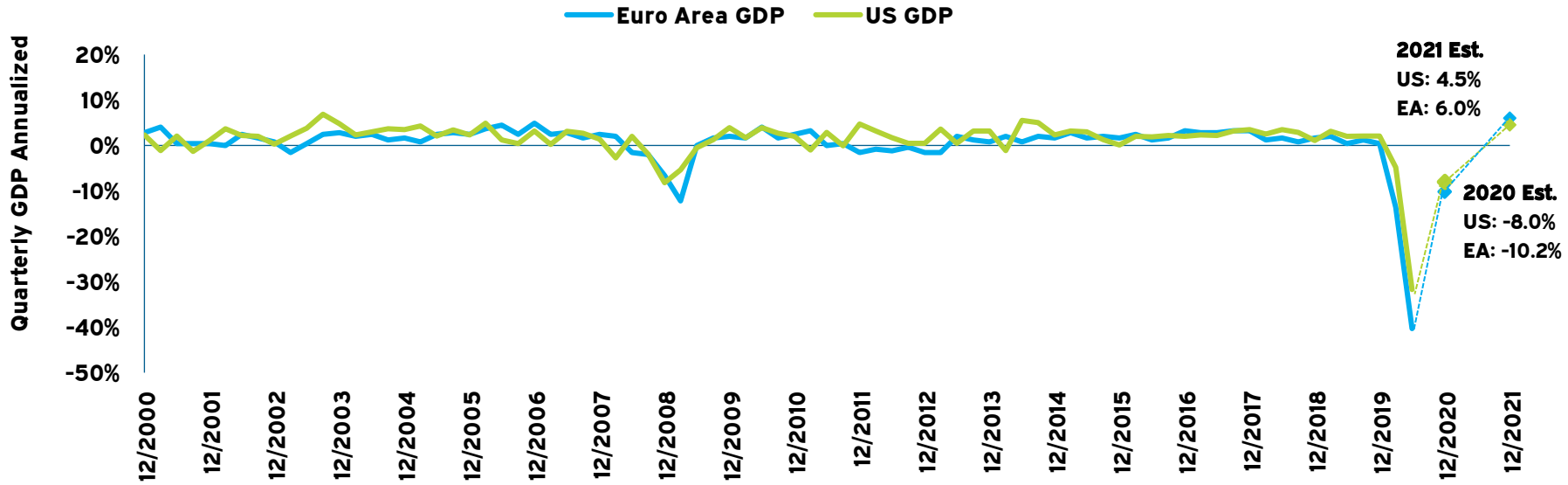
Declines in Business and Consumer Sentiment:

- Sentiment drives investment and consumption, which leads to increased recessionary pressures as sentiment slips.

Wealth Effect:

- As financial markets decline and wealth deteriorates, consumer spending will be impacted.

GDP Data Shows Impact of the Pandemic[1]

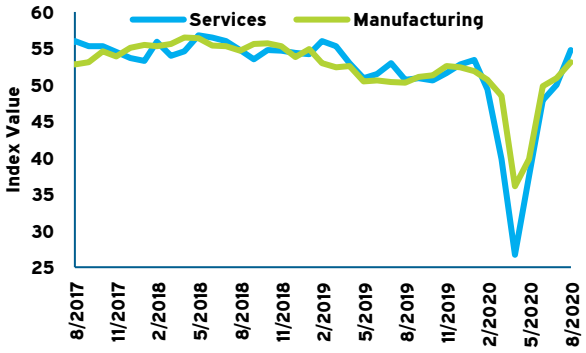


- The global economy faces major recessionary pressures this year, but optimism remains for improvements in 2021, as economies are expected to gradually reopen.
- In the US, second quarter GDP posted a record (annualized) decline of -31.7%, officially putting the US in a recession. Similarly, growth in the Euro Area declined by a record amount with the major economies in Germany, France, Italy, and Spain experiencing historic declines.
- Bloomberg Economics estimates that third quarter US GDP growth could be as high as 21.2% (QoQ annualized).

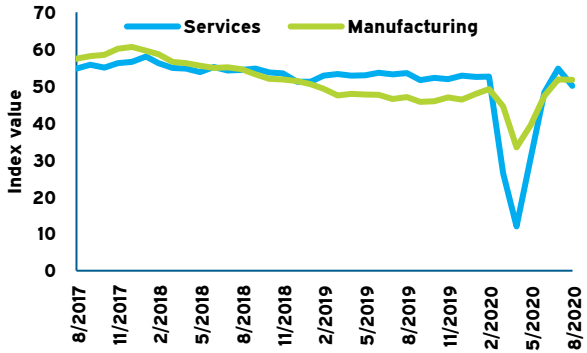
[1] Source: Bloomberg. Q2 2020 data represents the second estimate of GDP for the Euro Area and United States. Euro Area figures annualized by Meketa. Projections via June 2020 IMF World Economic Outlook and represent annual numbers.

Global PMIs

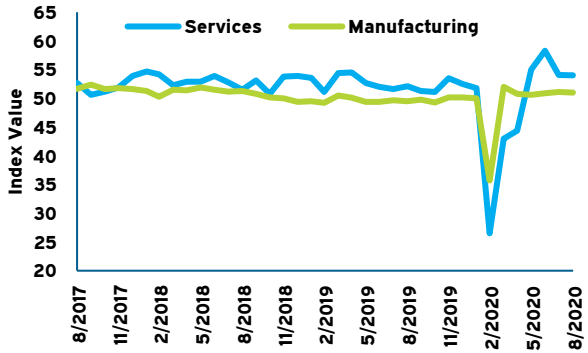
US PMI[1]



Eurozone PMI[2]



China PMI[3]



- Purchasing Managers Indices, (PMI) based on surveys of private sector companies, initially collapsed across the world to record lows, as output, new orders, production, and employment were materially impacted by closed economies.
- Readings below 50 represent contractions across underlying components and act as a leading indicator of economic activity, including the future paths of GDP, employment, and industrial production.
- The services sector was particularly hard hit by the stay-at-home restrictions in many places.
- As the Chinese economy reopened over the last few months, their PMI's, particularly in the service sector, recovered materially. In the US and Europe, the indices have also improved from their lows to above contraction levels.

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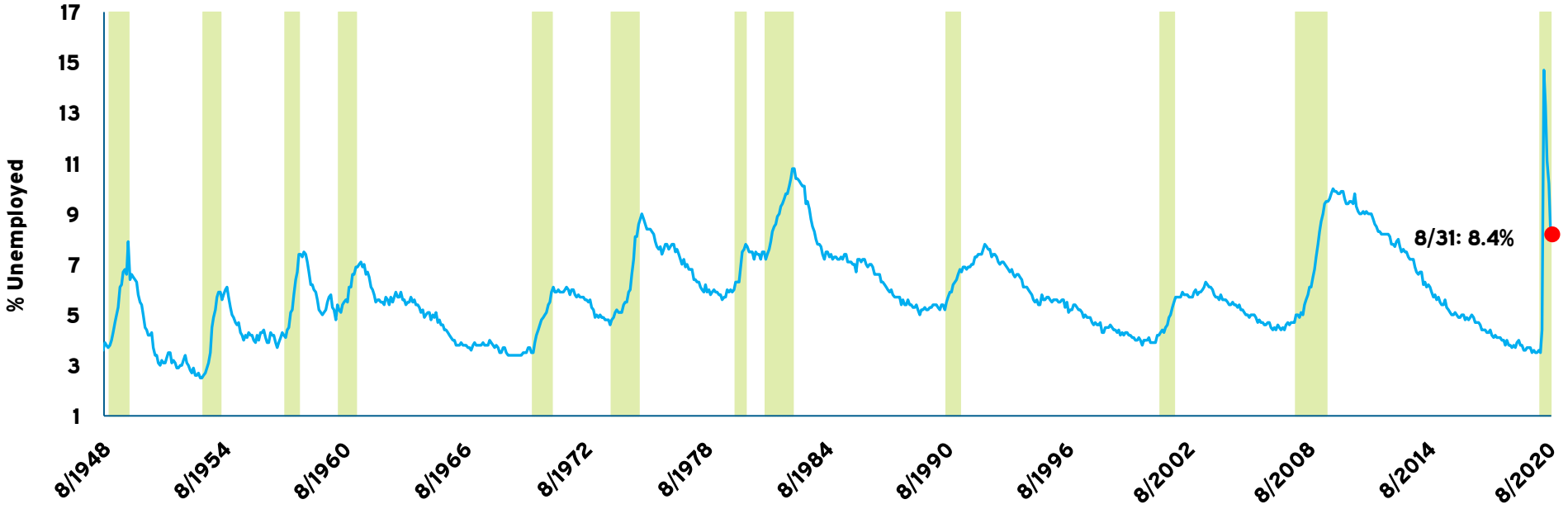
[1] Source: Bloomberg. US Markit Services and Manufacturing PMI. Data is as of August 2020.

[2] Source: Bloomberg. Eurozone Markit Services and Manufacturing PMI. Data is as of August 2020.

[3] Source: Bloomberg. Caixin Services and Manufacturing PMI. Data is as of August 2020.

US Unemployment Rate[1]

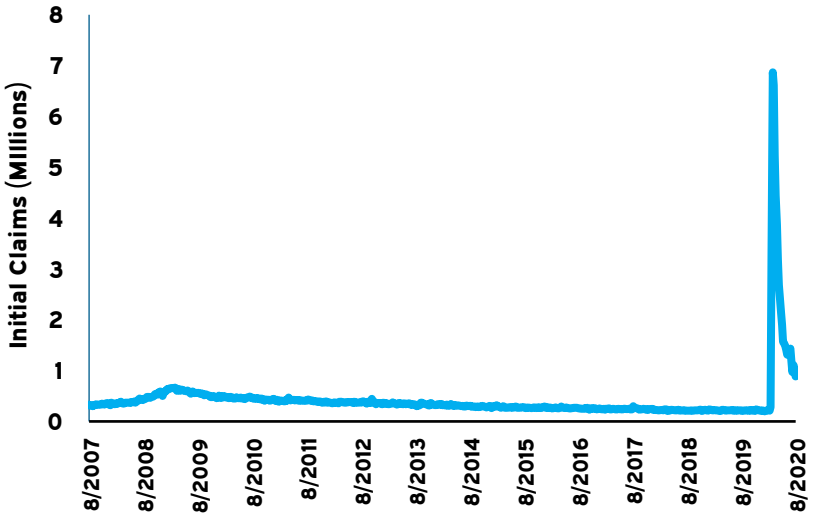


- In August, the unemployment rate continued its decline from the recent April 14.7% peak, falling to 8.4% as businesses and consumers emerged from the lockdown.
- Despite the improvement, unemployment levels remain well above pre-virus readings and are likely higher than reported due to issues related to some workers being misclassified. According to the Bureau of Labor Statistics, absent the misclassification issue, the August unemployment rate would be higher by 0.7%.
- The re-opening of some school districts, and upcoming holiday season, could lead to an increase in the unemployment rate going forward.

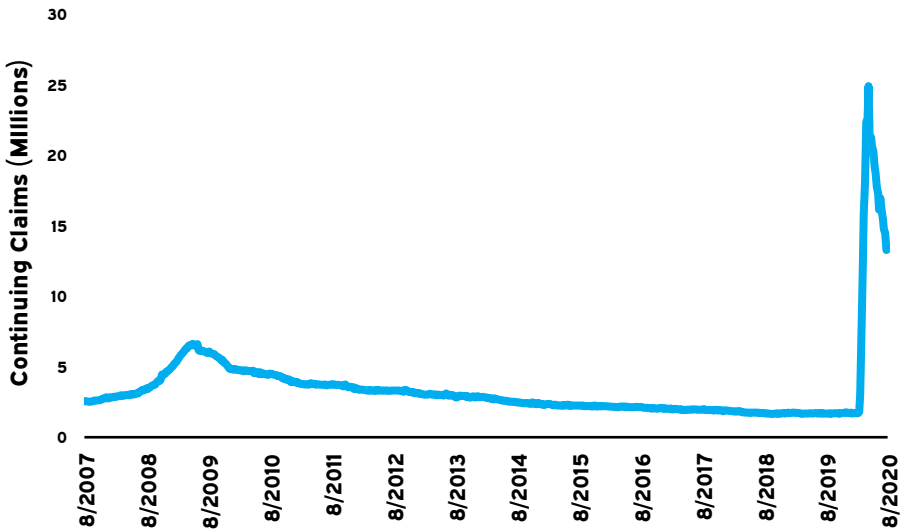
[1] Source: Bloomberg. Data is as of August 31, 2020. Bars represent recessions.

US Jobless Claims

US Initial Jobless Claims[1]



Continuing Claims[2]



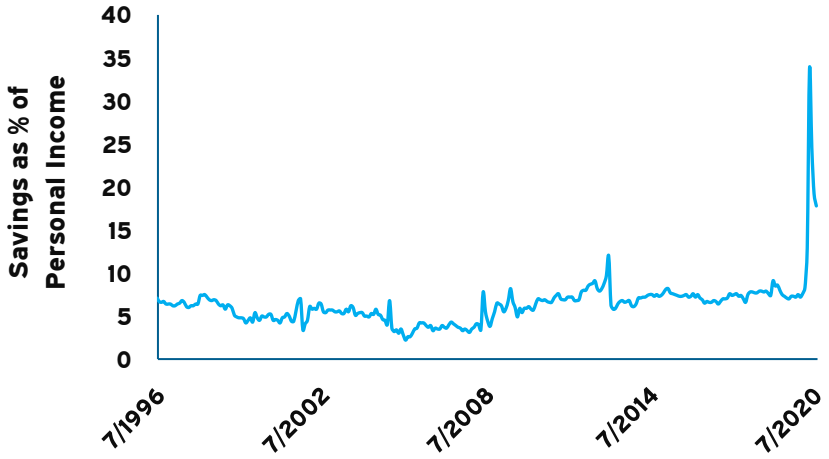
- Over the last 24 weeks, roughly 59.3 million people filed for initial unemployment. This level far exceeds the 22 million jobs added since the GFC, highlighting the unprecedented impact of the virus.
- Despite the continued decline in initial jobless claims to levels below 1.0 million per week, levels remain many multiples above the worst reading during the Global Financial Crisis.
- Continuing jobless claims (i.e., those currently receiving benefits) has also declined from record levels, but remains elevated at 13.4 million.

[1] Source: Bloomberg. First reading of seasonally adjusted initial jobless claims. Data is as of August 28, 2020.

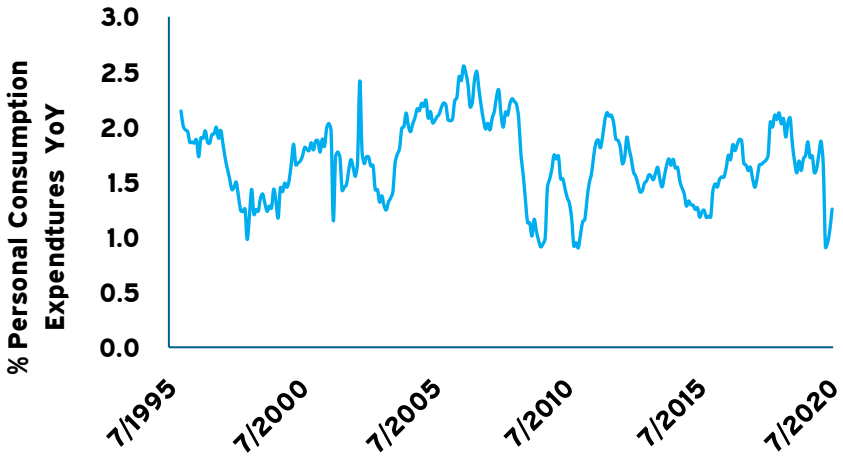
[2] Source: Bloomberg. US Continuing Jobless Claims SA. Data is as of August 28, 2020.

Savings and Spending

Savings Rate[1]



Consumer Spending[1]

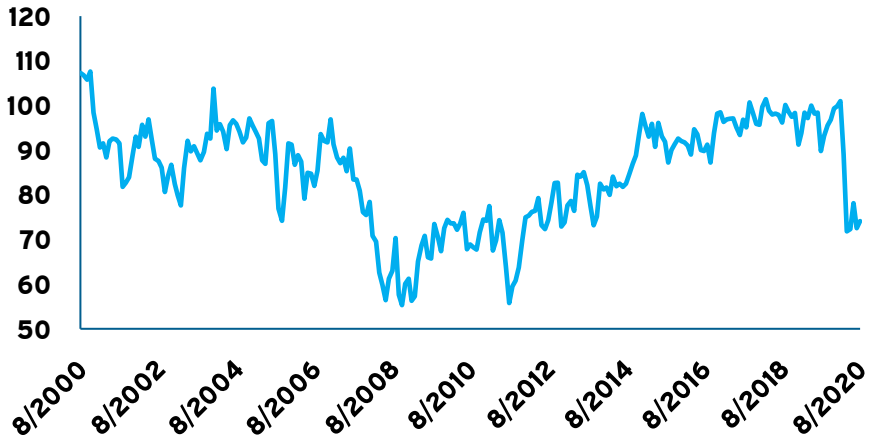


- Fiscal programs including stimulus checks, enhanced unemployment benefits, and loans to small businesses through the Paycheck Protection Program (PPP) have largely supported income levels through the shutdown.
- Despite the income support, the savings rate has increased due to the decline in consumer spending, driven by the initial lock-down of the economy, and by uncertainties related to the future of the job market and stimulus programs.
- More recently, the savings rate declined from its peak as spending increased with the economy slowly reopening.

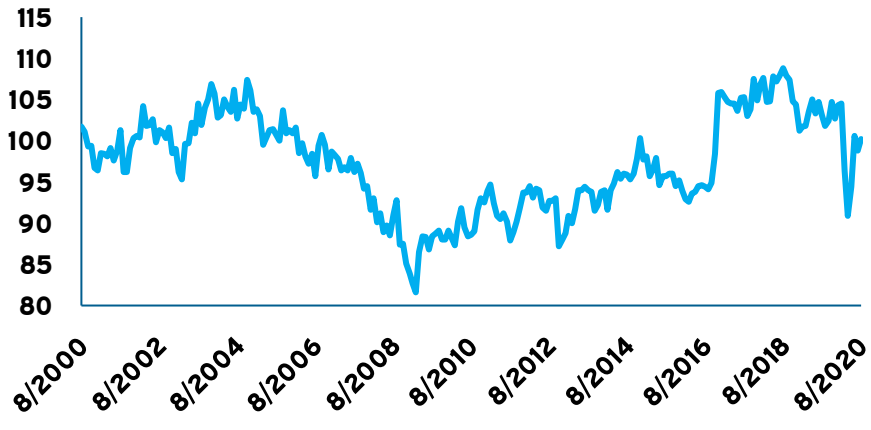
[1] Source: Bloomberg. Latest data is as of July 31, 2020.

Sentiment Indicators

University of Michigan Consumer Sentiment[1]



Small Business Confidence[2]



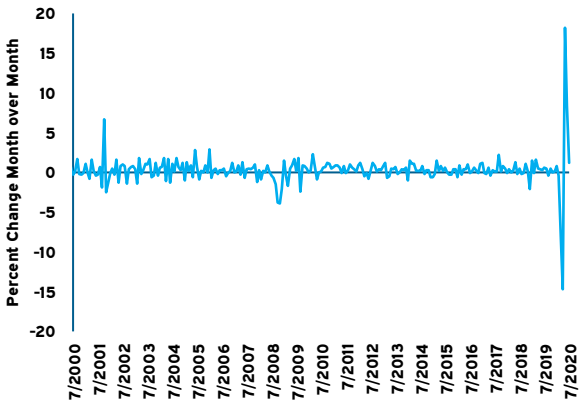
- A strong indicator of future economic activity are the attitudes of businesses and consumers today.
- Consumer spending comprises close to 70% of US GDP, making the attitudes of consumers an important driver of economic growth. Additionally, small businesses generate around half of US GDP, making sentiment in that segment important too.
- Sentiment indicators have shown some improvements as the economy re-opens, but they remain below prior levels.

[1] Source: Bloomberg. University of Michigan Consumer Sentiment Index. Data is as of August 31, 2020.

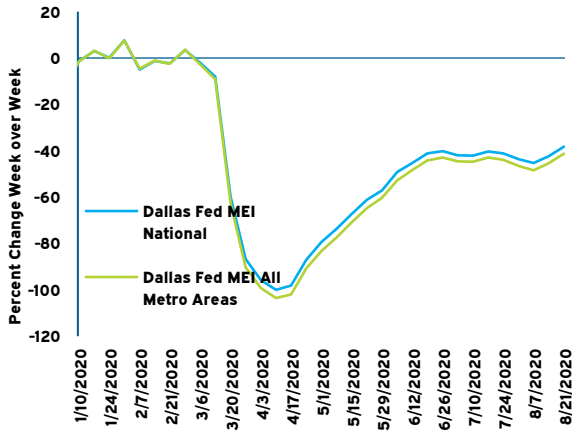
[2] Source: Bloomberg. NFIB Small Business Optimism Index. Data is as of August 31, 2020.

Some US Data has Improved

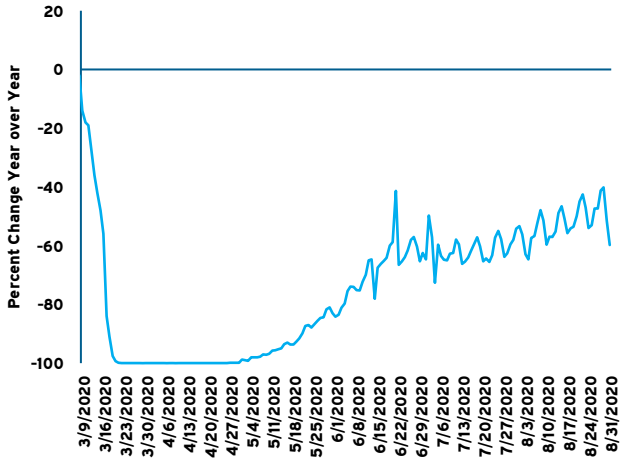
Retail Sales[1]



Dallas Fed Mobility and Engagement Index[2]



OpenTable Seated Diners YoY % Change[3]



- There have been improvements in high frequency data, but overall levels remain well below prior readings and have slowed in some cases given the recent spike in cases.
- Generally, people have become more active as restrictions eased and stores reopened. Retail sales recovered from a record decline with three consecutive months of growth as the economy reopened, but the pace of growth has been declining.
- Restaurants saw initial improvements before declining and leveling-off, as in-store dining has been cited as a key contributor to increases in infections.

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[1] Source: Bloomberg. Data is as of July 31, 2020 and represents the US Retail Sales SA MoM%

[2] Source: Bloomberg. Data is as of August 21, 2020 and represents the deviation from normal mobility behaviors induced by COVID-19 (formerly the "Social Distancing Index"). The index represents a weighted average of various lengths of time that a mobile device, like a cell phone, leaves its "home" or place of residence, and/or how long a device stays at home. A decline in this index represents a mobile device at home for a longer period of time than average.

[3] Source: Bloomberg. This data shows year-over-year seated diners at restaurants on the OpenTable network across all channels: online reservations, phone reservations, and walk-ins. Only states or cities with 50+ restaurants in the sample are included. All such restaurants on the OpenTable network in either period are included. Data is as of August 31, 2020. Index start date 2/19/20.

Looking Forward...

- There will be significant economic impact and a global recession.
  - How deep it will be and how long it will last depend on factors (below) that are unknowable at this time.
- The length of the virus and country responses will be key considerations.
  - As of now, it is not clear the end is in sight, particularly given the recent increases in cases in certain areas; however, individual countries are attempting to lay the groundwork to support a recoveries in their economies.
- Central banks and governments are pledging support, but will it be enough?
  - Market reactions to announced policies have been positive, but additional support will likely be required until the virus gets better contained.
- Expect heightened market volatility should economies start to shut back down given the recent spike in cases.
  - This has been a consistent theme recently; volatility is likely to remain at risk of spiking again for the foreseeable future.
- It is important to retain a long-term focus.
  - History supports the argument that maintaining a long-term focus will ultimately prove beneficial for diversified portfolios.

Prior Drawdowns and Recoveries from 1926-2020[1]

Period	Peak-to-Trough Decline of the S&P 500	Approximate Time to Recovery
Sept 1929 to June 1932	-85%	266 months
February 1937 to April 1942	-57%	48 months
May 1946 to February 1948	-25%	27 months
August 1956 to October 1957	-22%	11 months
December 1961 to June 1962	-28%	14 months
February 1966 to October 1966	-22%	7 months
November 1968 to May 1970	-36%	21 months
January 1973 to October 1974	-48%	69 months
September 1976 to March 1978	-19%	17 months
November 1980 to August 1982	-27%	3 months
August 1987 to December 1987	-32%	19 months
July 1990 to October 1990	-20%	4 months
July 1998 to August 1998	-19%	3 months
March 2000 to October 2002	-49%	56 months
October 2007 to March 2009	-57%	49 months
February 2020 to August 2020	-34%	6 months
Average	**-36%**	**39 months**
Average ex. Great Depression	**-33%**	**24 months**

- As markets have fully recovered to above pre-COVID levels, questions remain about the sustainability of the rally.
- The six month recovery period represents one of the shortest on record, similar to the historic decline.

[1] Source: Goldman Sachs.

Implications for Clients

- Portfolios have generally experienced significant improvements from the March lows.
- Even though equity markets have recovered from their lows, it is important to remain vigilant and be prepared to rebalance if volatility increases again.
  - Before rebalancing, consider changes in liquidity needs given the potential for cash inflows to decline in some cases.
  - Also, consider the cost of rebalancing if investment liquidity declines.
- Diversification works. The latest decline was an example of a flight to quality leading to gains in very high quality bonds.

Performance YTD
(through August 31, 2020)

S&P 500	ACWI (ex. US)	Aggregate Bond Index	Balanced Portfolio[1]
9.7%	-3.1%	6.9%	5.3%

- Meketa will continue to monitor the situation and communicate frequently.
  - The situation is fluid and the economic impact is uncertain at this stage.
- Please feel free to reach out with any questions.

[1] Source: InvestorForce. Balanced Portfolio represents 60% MSCI ACWI and 40% Bloomberg Barclays Global Aggregate.

Disclaimer, Glossary, and Notes

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PERFORMANCE DATA CONTAINED HEREIN REPRESENT PAST PERFORMANCE. PAST PERFORMANCE IS NO GUARANTEE OF FUTURE RESULTS.

Credit Risk: Refers to the risk that the issuer of a fixed income security may default (i.e., the issuer will be unable to make timely principal and/or interest payments on the security.)

Duration: Measure of the sensitivity of the price of a bond to a change in its yield to maturity. Duration summarizes, in a single number, the characteristics that cause bond prices to change in response to a change in interest rates. For example, the price of a bond with a duration of three years will rise by approximately 3% for each 1% decrease in its yield to maturity. Conversely, the price will decrease 3% for each 1% increase in the bond's yield. Price changes for two different bonds can be compared using duration. A bond with a duration of six years will exhibit twice the percentage price change of a bond with a three-year duration. The actual calculation of a bond's duration is somewhat complicated, but the idea behind the calculation is straightforward. The first step is to measure the time interval until receipt for each cash flow (coupon and principal payments) from a bond. The second step is to compute a weighted average of these time intervals. Each time interval is measured by the present value of that cash flow. This weighted average is the duration of the bond measured in years.

Information Ratio: This statistic is a measure of the consistency of a portfolio's performance relative to a benchmark. It is calculated by subtracting the benchmark return from the portfolio return (excess return), and dividing the resulting excess return by the standard deviation (volatility) of this excess return. A positive information ratio indicates outperformance versus the benchmark, and the higher the information ratio, the more consistent the outperformance.

Jensen's Alpha: A measure of the average return of a portfolio or investment in excess of what is predicted by its beta or "market" risk. Portfolio Return- [Risk Free Rate+Beta*(market return-Risk Free Rate)].

Market Capitalization: For a firm, market capitalization is the total market value of outstanding common stock. For a portfolio, market capitalization is the sum of the capitalization of each company weighted by the ratio of holdings in that company to total portfolio holdings; thus it is a weighted-average capitalization. Meketa Investment Group considers the largest 65% of the broad domestic equity market as large capitalization, the next 25% of the market as medium capitalization, and the smallest 10% of stocks as small capitalization.

Market Weighted: Stocks in many indices are weighted based on the total market capitalization of the issue. Thus, the individual returns of higher market-capitalization issues will more heavily influence an index's return than the returns of the smaller market-capitalization issues in the index.

Maturity: The date on which a loan, bond, mortgage, or other debt/security becomes due and is to be paid off.

Prepayment Risk: The risk that prepayments will increase (homeowners will prepay all or part of their mortgage) when mortgage interest rates decline; hence, investors' monies will be returned to them in a lower interest rate environment. Also, the risk that prepayments will slow down when mortgage interest rates rise; hence, investors will not have as much money as previously anticipated in a higher interest rate environment. A prepayment is any payment in excess of the scheduled mortgage payment.

Price-Book Value (P/B) Ratio: The current market price of a stock divided by its book value per share. Meketa Investment Group calculates P/B as the current price divided by Compustat's quarterly common equity. Common equity includes common stock, capital surplus, retained earnings, and treasury stock adjusted for both common and nonredeemable preferred stock. Similar to high P/E stocks, stocks with high P/B's tend to be riskier investments.

Price-Earnings (P/E) Ratio: A stock's market price divided by its current or estimated future earnings. Lower P/E ratios often characterize stocks in low growth or mature industries, stocks in groups that have fallen out of favor, or stocks of established blue chip companies with long records of stable earnings and regular dividends. Sometimes a company that has good fundamentals may be viewed unfavorably by the market if it is an industry that is temporarily out of favor. Or a business may have experienced financial problems causing investors to be skeptical about is future. Either of these situations would result in lower relative P/E ratios. Some stocks exhibit above-average sales and earnings growth or expectations for above average growth. Consequently, investors are willing to pay more for these companies' earnings, which results in elevated P/E ratios. In other words, investors will pay more for shares of companies whose profits, in their opinion, are expected to increase faster than average. Because future events are in no way assured, high P/E stocks tend to be riskier and more volatile investments. Meketa Investment Group calculates P/E as the current price divided by the I/B/E/S consensus of twelve-month forecast earnings per share.

Quality Rating: The rank assigned a security by such rating services as Fitch, Moody's, and Standard & Poor's. The rating may be determined by such factors as (1) the likelihood of fulfillment of dividend, income, and principal payment of obligations; (2) the nature and provisions of the issue; and (3) the security's relative position in the event of liquidation of the company. Bonds assigned the top four grades (AAA, AA, A, BBB) are considered investment grade because they are eligible bank investments as determined by the controller of the currency.

Sharpe Ratio: A commonly used measure of risk-adjusted return. It is calculated by subtracting the risk free return (usually three-month Treasury bill) from the portfolio return and dividing the resulting excess return by the portfolio's total risk level (standard deviation). The result is a measure of return per unit of total risk taken. The higher the Sharpe ratio, the better the fund's historical risk adjusted performance.

STIF Account: Short-term investment fund at a custodian bank that invests in cash-equivalent instruments. It is generally used to safely invest the excess cash held by portfolio managers.

Standard Deviation: A measure of the total risk of an asset or a portfolio. Standard deviation measures the dispersion of a set of numbers around a central point (e.g., the average return). If the standard deviation is small, the distribution is concentrated within a narrow range of values. For a normal distribution, about two thirds of the observations will fall within one standard deviation of the mean, and 95% of the observations will fall within two standard deviations of the mean.

Style: The description of the type of approach and strategy utilized by an investment manager to manage funds. For example, the style for equities is determined by portfolio characteristics such as price-to-book value, price-to-earnings ratio, and dividend yield. Equity styles include growth, value, and core.

Tracking Error: A divergence between the price behavior of a position or a portfolio and the price behavior of a benchmark, as defined by the difference in standard deviation.

Yield to Maturity: The yield, or return, provided by a bond to its maturity date; determined by a mathematical process, usually requiring the use of a "basis book." For example, a 5% bond pays $5 a year interest on each $100 par value. To figure its current yield, divide $5 by $95—the market price of the bond—and you get 5.26%. Assume that the same bond is due to mature in five years. On the maturity date, the issuer is pledged to pay $100 for the bond that can be bought now for $95. In other words, the bond is selling at a discount of 5% below par value. To figure yield to maturity, a simple and approximate method is to divide 5% by the five years to maturity, which equals 1% pro rata yearly. Add that 1% to the 5.26% current yield, and the yield to maturity is roughly 6.26%.

$$\frac{\text{5\% (discount)}}{\text{5 (yrs. to maturity)}} = \text{1\% pro rata, plus 5.26\% (current yield)} = \text{6.26\% (yield to maturity)}$$

Yield to Worst: The lowest potential yield that can be received on a bond without the issuer actually defaulting. The yield to worst is calculated by making worst-case scenario assumptions on the issue by calculating the returns that would be received if provisions, including prepayment, call, or sinking fund, are used by the issuer.

NCREIF Property Index (NPI): Measures unleveraged investment performance of a very large pool of individual commercial real estate properties acquired in the private market by tax-exempt institutional investors for investment purposes only. The NPI index is capitalization-weighted for a quarterly time series composite total rate of return.

NCREIF Fund Index - Open End Diversified Core Equity (NFI-ODCE): Measures the investment performance of 28 open-end commingled funds pursuing a core investment strategy that reflects funds' leverage and cash positions. The NFI-ODCE index is equal-weighted and is reported gross and net of fees for a quarterly time series composite total rate of return.

Sources: Investment Terminology, International Foundation of Employee Benefit Plans, 1999.
The Handbook of Fixed Income Securities, Fabozzi, Frank J., 1991

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Throughout this report, numbers may not sum due to rounding.

Returns for periods greater than one year are annualized throughout this report.

Values shown are in millions of dollars, unless noted otherwise.

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS'
FINANCE AND AUDIT COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 17, 2020

A Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee was held on September 17, 2020 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER
Chair Isabel Becerra called the meeting to order at 2:03 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Isabel Becerra, Chair; Clayton Corwin (at 2:55 p.m.); Scott Schoeffel (All members at teleconference locations)

Members Absent: None

Others Present: Richard Sanchez, Interim Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENTS
There were no requests for public comment.

Chair Becerra reordered the agenda to hear Information Item 11. before Management Report 1.c. and to hear Report Item 10. after Report Item 4.

MANAGEMENT REPORTS
1. Chief Financial Officer Report
Nancy Huang, Chief Financial Officer, provided three updates during her report. The first was regarding the status of hospital directed payments. Ms. Huang noted that, last week, CalOptima received approximately $97 million from the Department of Health Care Services (DHCS) for three hospital directed payment programs. The programs are: private hospital directed payment (PHDP), enhanced payment program (EPP), and the quality incentive program (QIP). Both PHDP and EPP payments are based on encounter data for dates of services (DOS) from July through December 2018, with some prior period adjustments. The QIP is for the full 2019-20 fiscal year. Ms. Huang noted that

payments under these programs are scheduled to be released to participating hospitals before the end of September 2020.

Her second update was regarding CalOptima's development agreement extension request with the City of Orange. Ms. Huang noted that when CalOptima purchased the 505 City Parkway West building in Orange, the purchase included development rights to build a similar office tower with a parking structure. The current development agreement expires at the end of 2020. In December 2017, the CalOptima Board authorized staff to seek an extension. Staff has met with the City of Orange and has formally requested a six-year extension of the development agreement. Ms. Huang noted that staff plans to bring a request for approval of needed unbudgeted funds for this extension to the November Finance and Audit Committee (FAC) and then to the December Board for approval.

As noted at the top of the meeting, Chair Becerra reordered the agenda to hear Information Item 11. before Management Report 1.c.

INFORMATION ITEM

11. Intergovernmental Transfer Overview

Candice Gomez, Executive Director, Program Implementation, provided an Intergovernmental Transfer (IGT) overview. Ms. Gomez reviewed the background of IGTs, CalOptima's funding partners, and dollars received to date. The CalOptima Board has approved funding plans for IGT 1 through 9. For IGTs 1 through 7, the state allowed CalOptima to use the funds for enhanced benefits to existing Medi-Cal beneficiaries. However, beginning with IGT 8, the funds are considered part of the capitation revenue CalOptima receives and must be used for Medi-Cal covered services. Any expenditures of IGT funds that do not qualify as medical expenses are counted as part of CalOptima's administrative expenses by the state. Ms. Gomez also noted that COVID-19 had impacted some of the earlier IGTs, where grants were awarded to community-based organizations. Due to the pandemic, the scope of some of the grantees' projects has changed, and the Board has authorized time extensions to many of the grant awardees. This year, the Board authorized CalOptima's participation to pursue IGT 10 funding, which is estimated to total $66 million.

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Ms. Huang provided the third part of her CFO report, which addresses potential uses of IGT 10 funds, including partially offsetting the upcoming revenue shortfall from DHCS. She highlighted two main areas related to potential rate adjustments: 1) Medi-Cal Expansion Rates (MCE), and 2) Managed Medi-Cal Long Term Services and Support (MTLSS).

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for April 1, 2020 through June 30, 2020. The portfolio totaled approximately $1.7 billion as of June 30, 2020. Of this amount, $1.1 billion was in CalOptima's operating account and $585 million was included in CalOptima's Board-designated reserves.

Back to Agenda

Meketa Investment Group Inc., CalOptima's Investment Advisor, completed an independent review of the monthly investment reports and reported that all investments were compliant with Government Code section 53600 et seq., and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

3. Approve the Minutes of the May 21, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the April 20, 2020 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

4. Consider Recommending that the Board of Directors Accept and Receive and File the Fiscal Year 2019-20 CalOptima Audited Financial Statements

Stacy Stelzriede of Moss-Adams, LLP, CalOptima's independent financial auditor, presented the draft audit of the consolidated financial statement for the fiscal year ending June 30, 2020. A detailed review of the areas of audit emphasis were presented, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. Ms. Stelzriede reported that Moss-Adams will be issuing an unmodified opinion on the financial Statements indicating that the FY 2019-20 financial statements fairly state the financial condition of CalOptima in all material respects.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors accept and receive and file the FY 2020 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adam, LLP. (Motion carried 2-0-0; Director Corwin absent)***

10. Consider Recommending that the Board of Directors' Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2021

Director Schoeffel did not participate in this item due to potential conflicts of interest and did not participate in the discussion and vote.

Brigette Gibb, Executive Director, Human Resources, introduced the item.

Action: ***On motion of Director Corwin seconded and carried, the Committee recommended that Board of Directors: 1.) Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental and vision for CalOptima employees and eligible retirees (and their dependents), and basic life, accidental***

death and dismemberment, short-term disability and long-term disability insurance, and employee assistance program, and flexible spending account for Calendar Year 2021 in an amount not to exceed $23 million which includes the following proposed changes: a.) A decrease in employer contributions (based on the percentage of premium the employer pays from each plan), as a result of a 6.6% reduction in premium rates, reducing costs to CalOptima for CY 2021 in an amount of $1,444,451; b.) The addition of a new option for the Cigna Health Care (Cigna) HMO medical plan (Select Network) offered alongside the current full network Cigna HMO plan for active employees and eligible retirees with reduced premiums, which could result in an estimated cost savings of as much as $367,464 if employees select this plan over those with more expensive employee contribution rates; c.) An increase in employee contributions at each tier level for the current full network Cigna HMO plan to mirror the same employee contribution schedule as the Kaiser HMO medical plan; d.) A continuation of employer contributions for CY 2021 in an estimated amount of $182,500 to fund the Health Savings Accounts (HSA) monthly for employees currently enrolled in the Cigna High Deducible Health Plan; 2) Authorize the acceptance of the premium holiday in the amount of $125,000 received from Cigna Healthcare; and 3) Authorize the receipt and expenditures for CalOptima staff wellness programs from $25,000 in funding received from the Cigna Wellness/Health Improvement Fund for CY 2021. (Motion carried 2-0-0; Director Schoeffel absent)

5. Consider Recommending that the Board of Directors' Reappointment to the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors reappoint David Young to the Board of Directors' Investment Advisory Committee for a two-year term beginning October 1, 2020. (Motion carried 3-0-0)***

6. Consider Recommending Board of Directors' Appointment to the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors appoint the following two individuals to the Board's Investment Advisory Committee for two-year terms beginning October 1, 2020: 1.) Collen Clark; and 2.) David Hutchison. (Motion carried 3-0-0)***

7. Consider Recommending Board of Directors' Authorize COVID-19 Related Unbudgeted Expenditures

Ms. Huang noted that the title on the agenda should reflect that this is a ratification due to timing of the purchases and that this will be corrected on the October Board agenda.

Back to Agenda

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $137,802. (Motion carried 3-0-0)***

8. Consider Recommending Board of Directors' Authorization of Proposed Budget Allocation Changes in the CalOptima FY 2020-2021 Operating Budget

Ladan Khamseh, Chief Operating Officer, introduced the item.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors authorize the reallocation of the following budgeted funds from Medi-Cal: Other Operating Expenses to fund the Informatica Data Masking Software Maintenance license fee through June 30, 2021: 1) $67,950 from the Cloud Government/Storage Subscription; and 2) $67,950 from the Computer Equipment. (Motion carried 3-0-0)***

9. Consider Recommending Board of Directors' consider Authorizing the Ratification of Budget Reallocation changes in the CalOptima FY 2020-21 Capital Budget for Various Information Services Capital Projects

Staff noted that the agenda title incorrectly reflects that this item is a reallocation and should reflect that it is a reapportionment.

Ms. Huang introduced the item.

Action: ***On motion of Director Schoeffel seconded and carried, the Committee recommended that the Board of Directors authorize the ratification of reapportionment of budgeted funds among capital expense categories for various information services capital projects. (Motion carried 3-0-0)***

INFORMATION ITEMS

12. March 2020 Financial Summary

Ms. Huang briefly responded to Director Corwin's question regarding the operating deficit for the month of July 2020.

The following Information Items were accepted as presented:

13. CalOptima Information Security Update
14. Quarterly Operating and Capital Budget
15. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Whole-Child Model Financial Report
    c. Health Homes Financial Report
    d. Reinsurance Report
    d. Health Network Financial Report
    e. Contingency Contract Report

Back to Agenda

Richard Sanchez, Interim Chief Executive Officer, suggested that Committee members receive an overview of the Office of Compliance from CalOptima's Compliance Officer, Silver Ho, at the next Finance and Audit Committee (FAC) meeting.

COMMITTEE MEMBER COMMENTS

Director Schoeffel welcomed members to the FAC.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 3:33 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 19, 2020

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MINUTES

MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS'
INVESTMENT ADVISORY COMMITTEE

July 20, 2020

A virtual meeting of the CalOptima Board of Directors' Investment Advisory Committee (IAC) was held on Monday, July 20, 2020, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER
Chair Patrick Moore called the meeting to order at 3:02 p.m. and led the Pledge of Allegiance.

ROLL CALL

Members Present: Chair Patrick Moore, Caroline Harkins, Nancy Huang, Rodney Johnson, David Young

Others Present: Hannah Schriner, Jared Pratt, Meketa Investment Group; Asha Joshi, Darren Marco, Payden & Rygel; Erin Klepper, Drew Matus, Scott Pavlak, MetLife Investment Management; Seth Tekata, Tony Mellville, Wells Capital Management; Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Jason Kaing, Controller; Eric Rustad, Director, Financial Analysis; Kelly Klipfel, Director, Financial Compliance; Joyce Mellinger, Accounting Manager; Faye Heidari, Accounting Supervisor; Junna Yeo, Project Manager Senior; Pamela Reichardt, Executive Assistant

MINUTES

Approve Minutes of the April 20, 2020, Meeting of the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Chair Moore, seconded and carried, the Minutes of the April 20, 2020, Meeting of the CalOptima Board of Directors' Investment Advisory Committee were approved as presented. (Motion carried 5-0-0).***

PUBLIC COMMENT
There were no requests for public comment.

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MANAGEMENT REPORTS

Chief Executive Officer (CEO) Report
No report.

Chief Financial Officer (CFO) Report
CFO Nancy Huang gave a COVID-19 update. Over ninety percent (90%) of CalOptima staff is working remotely to continue providing services to our members and community. Orange County is seeing an increase in COVID cases. Staff has been working closely with our providers and the Orange County Health Care Agency to ensure our members have access to care during this global pandemic.

Ms. Huang also provided an update on the State and CalOptima's Fiscal Year (FY) 2020-21 budget. The final state budget provisions were consistent with staff's original budget assumptions. CalOptima's Board of Directors approved the FY 2020-21 Operating and Capital Budgets at the June 4, 2020, meeting. Ms. Huang reported that the state budget impacts CalOptima in three major areas: an increase in Medi-Cal enrollment, a delay of new program implementation, and reductions to managed care rates.

Ms. Huang reported that there were no major program or benefit changes in the final state budget. Given the current COVID environment, CalOptima's Board approved the FY 2020-21 budget with a $55 million deficit to support the healthcare delivery system in Orange County. Staff will monitor the overall financial performance closely and report back to the IAC at scheduled quarterly meetings.

Ms. Huang reported that staff will begin working on CalOptima's Annual Investment Policy in early August and will compile the initial edits and facilitate the review process. The policy will be presented at the October 19, 2020, IAC meeting, the November 19, 2020, Finance and Audit Committee Meeting (FAC), and final approval at the December 3, 2020, Board of Directors (BOD) Meeting. Staff will provide more information and edits to the IAC during the review process.

REPORTS

Consider Recommending David Young's Reappointment to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term

Action: ***On motion of Member Rodney Johnson, seconded and carried, the Investment Advisory Committee recommended the reappointment of David Young to the Board of Directors' Investment Advisory Committee for a two-year term beginning October 1, 2020. (Motion Carried 5-0)***

Consider Recommending Colleen Clark and David Hutchison's appointments to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term

Back to Agenda

Action: ***On motion of Member Nancy Huang, seconded and carried, the Investment Advisory Committee recommended the appointments of Colleen Clark and David Hutchison to the Board of Directors' Investment Advisory Committee for a two-year term beginning October 1, 2020. (Motion Carried 5-0)***

INFORMATION ITEMS

Presentation by Meketa Investment Group

Hannah Schriner, Vice President, introduced Jared Pratt, who joined the Meketa team earlier this year. Ms. Schriner gave a firm update and noted that the entire Meketa team has been working from home since April.

Ms. Schriner reported on the second quarter 2020 results. The one-year, total fund shows a net return of 2.815%. Quarter to date, the total fund return was 0.923% net of fees. Tier One and Tier Two portfolios all outperformed expectations, with positive results for all managers. Ms. Schriner reported that funds were in compliance for the quarter end as of June 30, 2020.

Jared Pratt, Investment Analyst, reported on the performance and custom peer group results for all managers.

Presentation by MetLife Investment Management

Erin Klepper, Associate Director, provided a firm overview and noted that the MetLife Team has been working from home. Juan Peruyero has joined the MetLife team, reporting to Scott Pavlik. Mr. Peruyero was unable to attend the meeting but will attend IAC meetings going forward. Ms. Klepper introduced Drew Matus, who will provide the economic update to the IAC.

Ms. Klepper reported on performance and gave an operating portfolio strategy update. Ms. Klepper noted that the portfolio was in compliance for the period ending June 30, 2020.
Drew Matus, Chief Market Strategist provided a global and U.S. economic update. Mr. Matus focused on China's economic activity and the difficulties economies will face trying to rebound during COVID. Mr. Matus also reported on the U.S. unemployment crisis.

Scott Pavlak, Managing Director, reported on the Federal Reserve Liquidity Programs and the Federal Reserve balance sheet. Mr. Pavlak also gave a CalOptima portfolio performance update.

Presentation by Payden & Rygel

Asha Joshi, Managing Principal, provided a firm update, the CalOptima portfolio performance update, and discussed overall themes within the U.S. economy.

Darren Marco, Senior Vice President, gave an operating portfolio update.

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Presentation by Wells Capital Management

Seth Takata, Regional Director, Insurance Investments, provided a firm update. Barry Sommers CEO, Wealth & Investment Management, has joined Wells Fargo and came from JP Morgan.

Tony Mellville, Senior Portfolio Manager, provided an operating portfolio update and a summary of market themes.

Financial Update

Nancy Huang, CFO, provided highlights of CalOptima's April 2020 financials. As of April 30, 2020, CalOptima's consolidated enrollment was 737,000, which was slightly below budget. Staff anticipates continued growth in Medi-Cal enrollment, primarily in the Temporary Assistance for Needy Families (TANF) Adult and Child aid categories. Financial highlights for April showed a $6.3 million change in net assets, which includes a $1.5 million loss from operations. This was offset by $7.8 million in income from investment activities. Year to date, CalOptima showed a total $54.6 million change in net assets, which contains $19.5 million in operating income and $35.1 million from investment income. CalOptima's year to date Medical Loss Ratio (MLR) was 95.9% and the Administrative Loss Ratio (ALR), including directed payments was 3.5%.

Ms. Huang also reviewed CalOptima's balance sheet as of April 30, 2020. Current assets were $1.4 billion, and current liabilities were $1.1 billion. Current ratio was 1.3, consistent with previous reporting period. The Board-designated reserves was $581 million, and the compliance ratio level was 1.91.

ADJOURNMENT

Hearing no further business, Chair Moore adjourned the meeting at 4:52 p.m.

/s/ Pamela Reichardt
Pamela Reichardt
Executive Assistant

Approved: October 19, 2020

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Finance and Audit Committee

Report Item

4. Consider Recommending Board of Directors' Approval of Proposed Changes to CalOptima Policy GA.3400: Annual Investments

Contact

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

Recommended Action

Recommend that the Board of Directors approve proposed changes to CalOptima Policy GA.3400: Annual Investments.

Background

At the February 27, 1996, meeting, the CalOptima Board of Directors (Board) approved the Annual Investment Policy (AIP) covering investments made between March 1, 1996 and February 28, 1997. In September 1996, the Board authorized the creation of the Investment Advisory Committee (IAC). The IAC reviews the AIP each year and recommends changes in said policy to the FAC and the Board for their respective approvals.

At the December 5, 2019, meeting, the Board approved changes to CalOptima Policy GA.3400: Annual Investments for Calendar Year 2020. At that time, staff, in conjunction with Meketa Investment Group, Inc., and CalOptima's investment managers, Payden & Rygel, MetLife and Wells Capital Management, recommended revisions to the AIP to:

- Clarify the primary benchmark for each investment portfolio for short term investments, and timeframes and responsible parties to review said benchmarks;
- Implement changes to conform to California Government Code (CGC) Local Agency Investment Guidelines;
- Clarify Investment Manager reporting requirement if diversification limits are exceeded;
- Clarify entities to receive listing or notification of prohibited investments from the Board; and
- Update glossary terms.

At the June 4, 2020, meeting, the Board approved changes to CalOptima Policy GA.3400: Annual Investments clarify counterparty diversification limits. The policy was revised to implement a 5% portfolio maximum limitation per credit counterparty and by instrument type to include all permitted investments except for U.S. Government or Agency securities effective June 1, 2020.

Discussion

Payden & Rygel, MetLife, and Wells Capital Management, CalOptima's investment managers, and Meketa Investment Group, Inc., CalOptima's investment adviser submitted proposed revisions to CalOptima Policy GA.3400: Annual Investments for Calendar Year (CY) 2021. Staff has reviewed the proposed revisions and recommends the following changes upon Board approval:

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- Changes to conform to language in the California Government Code (CGC) Local Agency Investment Guidelines:

    - Section III.D.2.c.i.: State and California Local Agency Obligations, allow short term investments with rating of F1 or better by Fitch Ratings Service; and

    - Section III.D.2.e.i.a) and b): Commercial Paper (CP), modify the criteria for allowable investments, to specify CP rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO).

- Section III.E.5.a.: Diversification Guidelines, establish a distinction between separate securitized trusts for the maximum issuer limits at the deal level since each is generally a unique "issuer."

In addition to the proposed changes noted above, the attached, red-lined version of the policy reflects some non-substantive formatting revisions.

At its October 19, 2020, meeting, the IAC recommended that the Finance and Audit Committee recommend that the Board approve the proposed changes to CalOptima Policy GA.3400.

Fiscal Impact
There is no immediate fiscal impact.

Rationale for Recommendation
The proposed changes to CalOptima Policy GA.3400: Annual Investments reflect the recommendations of CalOptima's investment managers, Payden & Rygel, MetLife, and Wells Capital Management and concurrence by CalOptima's investment adviser, Meketa Investment Group, Inc. These recommended changes continue to support CalOptima's goals to maintain safety of principal and achieve a market rate of return while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the California Government Code affecting local agencies noted for the CY 2021.

Concurrence
Board of Directors' Investment Advisory Committee
Meketa Investment Group, Inc.
Gary Crockett, Chief Counsel

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Attachments

1. Policy GA.3400: Annual Investments (redline and clean versions)

/s/ Richard Sanchez *11/10/2020*
Authorized Signature **Date**

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Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Administrative
Section:	Finance
Interim CEO Approval:	
Effective Date:	01/01/2018
Revised Date:	01/01/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20201119 FAC Review Only

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima invested on or after January 10, 2006 to ensure CalOptima's funds are prudently invested according to the Board of Directors' objectives and the California Government Code to preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.

   a. CalOptima shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with CalOptima's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

3. Liquidity: Liquidity is the second most important objective of CalOptima. It is important that each portfolio contain investments for which there is a secondary market and which offer the

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flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Treasurer's objectives.

    a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

        i. These performance Benchmarks shall be reviewed monthly by CalOptima staff, and quarterly by CalOptima's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CalOptima under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

1. CalOptima's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima's investments.

F. On an annual basis, CalOptima's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made are following this Policy.

1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

1. Authority to manage CalOptima's investment program is derived from an order of the Board of Directors.

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a. Management responsibility for the investment program shall be delegated to CalOptima's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

i. The Board of Directors may renew the delegation of authority annually.

b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima's Treasurer.

B. CalOptima Treasurer Responsibilities

1. The Treasurer shall be responsible for:

a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

b. The oversight of CalOptima's Investment Portfolio;

c. Directing CalOptima's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

a. The Operating Funds and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

c. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima.

2. The Investment Advisory Committee shall be responsible for the following functions:

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a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

b. Quarterly review of CalOptima's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

c. Provision of comments to CalOptima's staff regarding potential investments and potential investment strategies.

d. Performance of such additional duties and responsibilities pertaining to CalOptima's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima shall invest only in Instruments as permitted by the Code, subject to the limitations of this Policy.

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of two (2) years. Note that the Code allows for up to five (5) years.

b. Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

c. Private placement (144a) securities are prohibited.

d. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

a. U.S. Treasuries

i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

ii. U.S. Government securities include:

a) Treasury Bills: U.S. Government securities issued and traded at a discount;

b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

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d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or Bonds, that offer protection from Inflation. Coupon payments and underlying principal are automatically increased to compensate for Inflation, as measured by the Consumer Price Index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury Bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other Instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

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m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days

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Fund Type	Term Assigned	Term Allowed by the Code
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) CP of "prime" quality ~~of the highest ranking or of the highest letter and number rating as provided for~~, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO);

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by an NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by an NRSRO; and

c) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

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i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

a) A Broker-Dealer master repurchase agreement signed by the Investment Manager (acting as “Agent”) and approved by CalOptima;

b) The securities are held free and clear of any Lien by CalOptima's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined Capital, Surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any Lien, as agent for CalOptima's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima's custodian and CalOptima; and

d) The Agent will notify CalOptima's custodian and CalOptima if the Valuation of the Collateral Securities falls outside of policy. Upon direction by the CalOptima Treasurer, the Agent will liquidate the Collateral Securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such Valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year

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Fund Type	Term Assigned	Term Allowed by the Code
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by an NRSRO and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to CP, i.e., Medium Term Notes (MTNs).

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services; and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code; Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

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c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 Not Applicable Not Applicable	 Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are Instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt Instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA or better- or equivalent.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years stated final maturity 5 years stated final maturity	 5 years 5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce Risk.

a) They should have the same stability, Liquidity, and quality as traditional money market securities.

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b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years from the date of purchase.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

m. Supranational Obligations

i. The three (3) Supranational Institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

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Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio Liquidity should one (1) sector or company experience difficulties.

2. CalOptima's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	30% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	25% (Code)
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

b. Any one (1) repurchase agreement counterparty name:

If maturity/term is ⩽ 7 days: 50%
If maturity/term is > 7 days: 25%

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5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

   a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level~~.~~ with each securitized trust being considered a unique "issuer."

   b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

   a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

   b. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in the context of.

      i. The amount in relation to the total portfolio concentration;

      ii. Market and security specific conditions contributing to a breach of this Policy; and

      iii. The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security.

G. Rating Downgrades

1. CalOptima may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima's Treasurer, or Designee, within two (2) business days of the downgrade.

   a. A decision to retain a downgraded security shall be approved by CalOptima's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

2. The Investment Portfolio or Investment Portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

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3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide CalOptima's Treasurer, Investment Managers, Investment Advisory consultant, and Investment Advisory Committee with a list, should such a list be adopted by CalOptima in the future, of organizations that do not comply with this Policy and shall immediately notify CalOptima's Treasurer, Investment Managers, Investment Advisory consultant and Investment Advisory Committee of any changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §6509.7
B. California Government Code, §53600 et seq.
C. California Government Code, §53601(h), (k), (q)
D. California Government Code, §53635 et seq.
E. California Government Code. §53646, Subdivision (a) and Subdivision (b)
F. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

A. None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative

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IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima's regulatory compliance requirements; or b. Currently defined as CalOptima's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.

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Term	Definition
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Board of Directors with oversight responsibilities for all financial matters of CalOptima including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding CalOptima's Investment Policies, Procedures and Practices.

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Term	Definition
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.

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Term	Definition
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima's asset managers provide CalOptima with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima. Each asset manager uses a variety of market sources to determine individual Valuations.

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Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Administrative
Section:	Finance
Interim CEO Approval:	
Effective Date:	01/01/2018
Revised Date:	01/01/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

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I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima invested on or after January 10, 2006 to ensure CalOptima's funds are prudently invested according to the Board of Directors' objectives and the California Government Code to preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.

   a. CalOptima shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with CalOptima's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

3. Liquidity: Liquidity is the second most important objective of CalOptima. It is important that each portfolio contain investments for which there is a secondary market and which offer the

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flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Treasurer's objectives.

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

      i. These performance Benchmarks shall be reviewed monthly by CalOptima staff, and quarterly by CalOptima's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CalOptima under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

   1. CalOptima's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima's investments.

F. On an annual basis, CalOptima's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made are following this Policy.

   1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

   2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

   1. Authority to manage CalOptima's investment program is derived from an order of the Board of Directors.

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a. Management responsibility for the investment program shall be delegated to CalOptima's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

i. The Board of Directors may renew the delegation of authority annually.

b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima's Treasurer.

B. CalOptima Treasurer Responsibilities

1. The Treasurer shall be responsible for:

a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

b. The oversight of CalOptima's Investment Portfolio;

c. Directing CalOptima's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

a. The Operating Funds and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

c. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima.

2. The Investment Advisory Committee shall be responsible for the following functions:

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a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

b. Quarterly review of CalOptima's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

c. Provision of comments to CalOptima's staff regarding potential investments and potential investment strategies.

d. Performance of such additional duties and responsibilities pertaining to CalOptima's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima shall invest only in Instruments as permitted by the Code, subject to the limitations of this Policy.

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of two (2) years. Note that the Code allows for up to five (5) years.

b. Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

c. Private placement (144a) securities are prohibited.

d. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

a. U.S. Treasuries

i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

ii. U.S. Government securities include:

a) Treasury Bills: U.S. Government securities issued and traded at a discount;

b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

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d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or Bonds, that offer protection from Inflation. Coupon payments and underlying principal are automatically increased to compensate for Inflation, as measured by the Consumer Price Index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury Bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other Instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

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m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating, or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days

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Fund Type	Term Assigned	Term Allowed by the Code
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) CP of "prime" quality, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO);

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by an NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by an NRSRO; and

c) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

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i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

a) A Broker-Dealer master repurchase agreement signed by the Investment Manager (acting as "Agent") and approved by CalOptima;

b) The securities are held free and clear of any Lien by CalOptima's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined Capital, Surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any Lien, as agent for CalOptima's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima's custodian and CalOptima; and

d) The Agent will notify CalOptima's custodian and CalOptima if the Valuation of the Collateral Securities falls outside of policy. Upon direction by the CalOptima Treasurer, the Agent will liquidate the Collateral Securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such Valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year

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Fund Type	Term Assigned	Term Allowed by the Code
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by an NRSRO and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to CP, i.e., Medium Term Notes (MTNs).

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services; and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code; Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

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c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 Not Applicable Not Applicable	 Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are Instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt Instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA or better or equivalent.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years stated final maturity 5 years stated final maturity	 5 years 5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce Risk.

a) They should have the same stability, Liquidity, and quality as traditional money market securities.

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b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years from the date of purchase.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

m. Supranational Obligations

i. The three (3) Supranational Institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

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Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio Liquidity should one (1) sector or company experience difficulties.

2. CalOptima's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	30% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	25% (Code)
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

b. Any one (1) repurchase agreement counterparty name:

If maturity/term is $\leqslant$ 7 days: 50%
If maturity/term is > 7 days: 25%

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5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

   a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level with each securitized trust being considered a unique "issuer."

   b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

   a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

   b. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in the context of.

      i. The amount in relation to the total portfolio concentration;

      ii. Market and security specific conditions contributing to a breach of this Policy; and

      iii. The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security.

G. Rating Downgrades

1. CalOptima may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima's Treasurer, or Designee, within two (2) business days of the downgrade.

   a. A decision to retain a downgraded security shall be approved by CalOptima's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

2. The Investment Portfolio or Investment Portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

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3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide CalOptima's Treasurer, Investment Managers, Investment Advisory consultant, and Investment Advisory Committee with a list, should such a list be adopted by CalOptima in the future, of organizations that do not comply with this Policy and shall immediately notify CalOptima's Treasurer, Investment Managers, Investment Advisory consultant and Investment Advisory Committee of any changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §6509.7
B. California Government Code, §53600 et seq.
C. California Government Code, §53601(h), (k), (q)
D. California Government Code, §53635 et seq.
E. California Government Code. §53646, Subdivision (a) and Subdivision (b)
F. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

A. None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative

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IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima's regulatory compliance requirements; or b. Currently defined as CalOptima's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.

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Term	Definition
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Board of Directors with oversight responsibilities for all financial matters of CalOptima including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding CalOptima's Investment Policies, Procedures and Practices.

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Term	Definition
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.

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Term	Definition
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima's asset managers provide CalOptima with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima. Each asset manager uses a variety of market sources to determine individual Valuations.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Finance and Audit Committee

Report Item

5. Consider Recommending that the Board of Directors' Authorize an Amendment to the Amended and Restated Development Agreement with the City of Orange to Extend CalOptima's Development Rights

Contact

Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

Recommend that the Board of Directors:

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Amended and Restated Development Agreement with the City of Orange to extend its term for up to six (6) additional years, through ~~October 23~~ October 28, 2026, contingent upon approval of the Orange City Council; and
2. Authorize unbudgeted expenditures in an amount up to $105,000 from existing reserves for fees associated with the amendment through June 30, 2021.

Rev. 11/19/20

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten (10) stories and 200,000 square feet of office space, and a parking structure of up to five (5) levels and 1,528 parking spaces. The office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the 505 City Parkway West building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the Board authorized execution of an amended and restated Development Agreement with the City of Orange to extend CalOptima's development rights for up to six (6) additional years, until October 28, 2020. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The CalOptima Board agreed to pay a required $200,000 public benefit fee in periodic payments to the City of Orange in exchange for the extension.

At its August 4, 2016 and December 1, 2016, meetings, the CalOptima Board authorized contracts with real estate consultant, Newport Real Estate Services, Inc., to evaluate options for CalOptima's current development rights and to create a site plan. Newport Real Estate Services completed the evaluation and presented the requested information to the CalOptima Finance and Audit Committee (FAC) on February 16, 2017. The FAC recommended the Board issue a Property and Associated Development Rights Request for Information (RFI) to gauge potential interest and options available. The Board approved the issuance of an RFI at its March 2, 2017, meeting.

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The RFI response period closed on April 21, 2017, with only one response received. The limited response and staff's informal discussions with industry representatives during the RFI process primarily reflected limited interest in commercial office space development at that time.

At its December 7, 2017, meeting, the Board authorized contacting the City of Orange to explore extension of the existing Development Agreement for as long as possible, and to broaden the rights from commercial/office to include urban mixed use, including transitional housing.

In 2018, CalOptima staff contacted the City of Orange to informally discuss the extension of the Development Agreement as well as the possibility of expanding its scope. During these discussions, the City expressed openness to extending the Development Agreement as well as considering expanding the scope to include "urban mixed use." However, the City expressed concern about the possibility of including transitional housing as the City already has several homeless housing arrangements in various, locations consistent with the City's General Plan, and noted that the 605 Project Site was not an ideal site for any type of transitional or permanent supportive housing given the proximity of commercial and retail elements nearby.

Discussion

On June 24, 2020, staff sent a request to amend the terms of the Development Agreement with the City of Orange. The amendment would extend CalOptima's development rights, under the current terms, for up to six (6) additional years, until October 28, 2026.

Under the proposed amendment, CalOptima will pay additional public benefit fees to the City of Orange. The total cost of the fees is up to $300,000, divided into installment payments over the term of the extension. With each payment of $100,000, the Development Agreement will remain in effect for an additional two-year period. Specifically, CalOptima will make the payments in three (3) installments:

- $100,000 within forty-five (45) days of mutual execution of the amendment;
- $100,000 no later than fifteen (15) days prior to the expiration of the First Extended Term; and
- $100,000 no later than fifteen (15) days prior to the expiration of the Second Extended Term.

This payment structure allows development flexibility to CalOptima to further determine its office space needs. In addition to the public benefit fees, CalOptima will pay administrative costs associated with the preparation and processing of the Development Agreement in an amount up to $5,000.

The Amendment to the Amended and Restated Development Agreement was approved by the City of Orange Planning Commission on October 19, 2020, and will be considered at a future Orange City Council meeting.

Fiscal Impact

The recommended action is an unbudgeted item. An allocation of up to $105,000 from existing reserves will fund this action through June 30, 2021. Upon Board approval, Management will include the remaining allocation of up to $200,000 for the extended terms in future operating budgets.

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Rationale for Recommendation

The Development Agreement with the City of Orange provides CalOptima the opportunity to provide for future space needs in the event CalOptima requires additional office space. At the same time, the development rights are a valuable asset that can be severed from the existing parcel if CalOptima finds that CalOptima's construction of a separate office building and parking structure is not practical, feasible, or otherwise in the best interest of the organization.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Draft First Amendment to Amended and Restated Development Agreement
3. Ordinance No. xx-20: An Ordinance of the City Council of the City of Orange Approving a First Amendment to Amended and Restated Development Agreement
4. CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
5. CalOptima Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
6. NRES PowerPoint Presentation dated February 16, 2017: Long-Range Strategic Real Estate Plan – Excess Real Estate Development or Disposition Update
7. CalOptima Board Action dated December 7, 2017, Consider Actions Related to CalOptima's Agreement with the City of Orange

/s/ Richard Sanchez — *11/10/2020*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
City of Orange	300 E. Chapman Avenue	Orange	CA	92866

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 E. Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

FIRST AMENDMENT TO AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of _____, 2020

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

FIRST AMENDMENT TO
AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This First Amendment ("First Amendment") to the Amended and Restated Development Agreement ("Agreement") is made in Orange County, California as of ________, 2020, by and between the CITY OF ORANGE, a municipal corporation ("City"), and the ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("Developer"). City and Developer shall be referred to collectively as the "Parties."

RECITALS

This First Amendment is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

A. City and Developer entered into an Amended and Restated Development Agreement effective December 10, 2014 (the "Agreement").

B. The Agreement was set to expire on October 28, 2020.

C. The Parties wish to amend the Agreement and **Exhibit "D"** to provide for an extension of its term for up to six (6) additional years on the terms and conditions contained herein.

D. Pursuant to Government Code section 65867.5 and Orange Municipal Code section 17.44.100, the City Council finds that: (i) this Amendment and any Future Approvals of the Project is consistent with the objectives, policies, general land uses, and programs specified in the City's General Plan and any applicable specific plan or redevelopment plans; (ii) this Amendment is compatible with the uses authorized in the district or planning area in which the real property will be located; (iii) this Amendment is in conformity with the public necessity, public convenience, general welfare, and good land use practices; (iv) this Amendment is in the best interest of and not in detriment to the public health, safety and general welfare of the residents in the City and the surrounding region; (v) this Amendment will not adversely affect the orderly development of property in the City; and (vi) this Amendment is being entered into pursuant to and in compliance with the requirements of Government Code section 65867.

NOW THEREFORE, the Parties agree as follows:

1. Section 12 of the Agreement, "Term of Agreement," shall be amended in its entirety to read as follows:

> 12. **Revised Term of Agreement**. This First Amendment shall become operative and shall commence upon the date the ordinance approving this First Amendment, becomes effective. Subject to payment by Developer of the applicable Public Benefit Fees in the amounts and at the times identified in **First Amended Exhibit "D,"** attached hereto, this Agreement shall remain in effect for a period of up to twelve (12) years from the Original Termination Date unless this Agreement is terminated, modified

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or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth in **First Amended Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified in **First Amended Exhibit "D"**.

(a) **First Payment of Public Benefit Fees.** Within forty-five (45) days of mutual execution of this First Amendment by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee as identified in **First Amended Exhibit "D."** Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) additional years, such two (2) year period being the **"First Extended Term."**

(b) **Second Payment of Public Benefit Fees.** If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the First Extended Term, then Developer shall pay to the City the Second Public Benefit Fee as identified in **First Amended Exhibit "D"** no later than the time set forth in **First Amended Exhibit "D."** Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for a period of two (2) additional years from the expiration of the First Extended Term, such two (2) year period being the **"Second Extended Term."**

(c) **Third Payment of Public Benefit Fees.** If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Second Extended Term, then Developer shall pay to the City the Third Public Benefit Fee as identified in **First Amended Exhibit "D"** no later than the time set forth in **First Amended Exhibit "D."** Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for a period of two (2) additional years from the expiration of the Second Extended Term, such two (2) year period being the **"Third Extended Term."**

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the terms hereof or arising from the duties of the Parties as prescribed in this Agreement.

2. Exhibit "D" of the Agreement shall be replaced in its entirety with the attached **First Amended Exhibit "D,"** which is incorporated herein.

3. This First Amendment amends, as set forth herein, the Agreement and, except as specifically amended hereby, the Agreement shall remain in full force and effect. To the extent that there is any conflict or inconsistency between the terms and provisions of this First

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Amendment and the terms and provisions of the Agreement, the terms and provisions of this First Amendment shall control and govern the rights and obligations of the parties.

4. This First Amendment shall become operative upon the date the ordinance approving this First Amendment becomes effective.

[Remainder of page intentionally left blank; signatures on next page]

"CITY"

CITY OF ORANGE, a municipal corporation

By: _____
Mark A. Murphy, Mayor

ATTEST:

_____
Pamela Coleman, City Clerk

APPROVED AS TO FORM:

_____
Mary E. Binning
Senior Assistant City Attorney

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima

By: _____
Print name:_____
Title:_____

ACKNOWLEDGMENT

State of California
County of Orange

On _____ before me, _____, a Notary Public, personally appeared _____
_____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

(Seal)

ACKNOWLEDGMENT

State of California
County of Orange

On _____ before me, _____, a Notary Public, personally appeared _____
_____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

(Seal)

FIRST AMENDED EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section 12 "**Revised Term of the Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of the First Amendment by Developer and the City, Developer shall pay to the City the sum of $100,000 (the "**First Public Benefit Fee**"). Such payment will initiate the First Extended Term.

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Extended Term, then Developer shall pay to the City the sum of $100,000 (the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Extended Term. Such payment will initiate the Second Extended Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Second Extended Term, then Developer shall pay to the City the sum of $100,000 (the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Second Extended Term. Such payment will initiate the Third Extended Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

ORDINANCE NO. xx-20

AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF ORANGE APPROVING A FIRST AMENDMENT TO AMENDED AND RESTATED DEVELOPMENT AGREEMENT (AGR. NO. 4545.OC) BY AND BETWEEN THE CITY OF ORANGE AND ORANGE COUNTY HEALTH AUTHORITY D.B.A. CALOPTIMA FOR A DEVELOPMENT PROJECT ON THE "605 BUILDING SITE," LOCATED ON THE SOUTHEAST CORNER OF LEWIS STREET AND CITY PARKWAY WEST (605 CITY PARKWAY WEST)

WHEREAS, Section 65864 et seq. of the California Government Code authorizes cities to enter into a Development Agreement with any person having a legal or equitable interest in real property for the development of such property; and

WHEREAS, the City Council ("City Council") of the City of Orange ("City") has adopted Chapter 17.44 of the Orange Municipal Code ("OMC"), which establishes procedures for the processing and approval of Development Agreements; and

WHEREAS, by the adoption of Ordinance No. 19-04 on September 28, 2004, the City Council approved that certain Development Agreement by and between the City and CA-The City Limited Partnership, a Delaware limited partnership ("Original Developer"), relating to certain real property located in the City of Orange commonly referred to as the "City Plaza Two Site" and the "605 Building Site", which are more particularly described in the Development Agreement, recorded in the Official Records of the County of Orange ("Official Records") on January 6, 2005 as Instrument No. 2005000013339 ("Original Development Agreement"); and

WHEREAS, by the adoption of Ordinance No. 20-05 on January 10, 2006, the City Council of the City of Orange approved a First Amendment to the Original Development Agreement, which was recorded in the Official Records on January 24, 2006 as Instrument No. 2006000051175; and

WHEREAS, by the adoption of Ordinance No. 13-06 on September 12, 2006, the City Council approved a Second Amendment to the Original Development, which was recorded in the Official Records on October 17, 2006 as Instrument No. 2006000698031; and

WHEREAS, the Orange County Health Authority, doing business as CalOptima, is the assignee and successor-in-interest to the Original Development Agreement as it relates to the 605 Building Site only and the City Council memorialized that assignment by the adoption of Ordinance No. 06-14 on November 25, 2014, approving that certain Amended and Restated Development Agreement by and between the City of Orange and CalOptima, the original of which was recorded in the Official Records on December 11, 2014, as Instrument No. 2014000535189, City Agreement No. 4545.OC ("Amended and Restated Development Agreement"); and

WHEREAS, CalOptima has made an application to the City to enter into a First Amendment to the Amended and Restated Development Agreement to extend the Term of the Amended and Restated Agreement by six years; and

WHEREAS, Section 65868 of the California Government Code and OMC Section 17.44.160 permit the amendment of the Amended and Restated Agreement by mutual consent of the parties to the agreement, pursuant to the same procedure as for entering into a Development Agreement, namely that a noticed public hearing must be held by both the Planning Commission and the City Council and such amendment, if approved, must be approved by ordinance; and

WHEREAS, an environmental review was conducted by the City, as the "lead agency", under the California Environmental Quality Act ("CEQA") to evaluate the projects described in the Original Development Agreement, together with development projects for two other separate development sites owned by the Original Developer or its affiliates. As a result of the environmental review, Final Environmental Impact Report 1612-01 ("Final ElR") was prepared and certified by the City Council in accordance with CEQA on October 9, 2001; and

WHEREAS, further environmental review was conducted by the City at the time the Original Developer applied for the Original Development Agreement. In compliance with CEQA and the State CEQA Guidelines, the City prepared an Addendum to the Final ElR because "none of the conditions described in Section 15162 (of the State CEQA Guidelines) calling for the preparation of a subsequent ElR or negative declaration had occurred" in connection with the Developer's application for the Development Agreement; and

WHEREAS, due to the nature of the proposed First Amendment to the Amended and Restated Development Agreement, this City Council again finds and determines that "none of the conditions described in Section 15162 (of the State CEQA Guidelines) calling for the preparation of a subsequent ElR or negative declaration have occurred"' in connection with the proposed First Amendment to the Amended and Restated Development Agreement; and

WHEREAS, in accordance with State and local law, on October 19, 2020, the Planning Commission of the City of Orange conducted a duly noticed public hearing on the proposed First Amendment to the Amended and Restated Development Agreement in substantially the form attached to this Ordinance as Exhibit “A,” considered information presented by City staff and public testimony regarding the proposed First Amendment to the Amended and Restated Development Agreement, and, by a vote of not less than a majority of its total membership, recommended that the City Council approve the First Amendment to the Amended and Restated Development Agreement; and

WHEREAS, in accordance with State and local law, on November 10, 2020, the City Council conducted a duly noticed public hearing on the proposed First Amendment to the Amended and Restated Development Agreement, reviewed and considered proposed First Amendment to the Amended and Restated Development Agreement, and information presented by City staff and heard public testimony regarding the proposed First Amendment to the Amended and Restated Development Agreement.

NOW, THEREFORE, THE CITY COUNCIL OF THE CITY OF ORANGE DOES ORDAIN AS FOLLOWS:

SECTION I:

The City Council finds that a public hearing has been held before this City Council pursuant to the procedures described in Chapter 17.44 of the Orange Municipal Code. At the hearing, the City Council has considered testimony presented by the public and the Planning Commission's recommendation to approve the First Amendment to the Amended and Restated Development Agreement between the City of Orange and CalOptima.

SECTION II:

The City Council hereby finds that the First Amendment to the Amended and Restated Development Agreement between the City of Orange and CalOptima:

A. Is consistent with the objectives, policies, general land uses, and programs specified in the General Plan; and

B. Is compatible with the uses authorized in, and the regulations prescribed for, the zoning district in which the 605 Building Site is and will be located, and is consistent with the City's Zoning Code; and

C. Is in conformity with and will promote public necessity, public convenience, general welfare, and good land use practices; and

D. Will be beneficial to the health, safety, and general welfare; and

E. Will not adversely affect the orderly development of property or the preservation of property values; and

F. Will promote and encourage the development of the proposed project by providing a greater degree of requisite certainty.

SECTION III:

The City Council approves and incorporates by reference the First Amendment to the Amended and Restated Development Agreement attached hereto as Exhibit "A." Within ten (10) days after this Ordinance takes effect and provided that CalOptima has first executed the First Amendment to the Amended and Restated Development Agreement in recordable form and delivered same to the City, the Mayor shall execute the First Amendment to the Amended and Restated Development Agreement in recordable form.

SECTION IV:

Within ten (10) days after the execution of the First Amendment to the Amended and Restated Development Agreement by all parties, the City Clerk is authorized and directed to record the First Amendment to the Amended and Restated Development Agreement in the Official Records.

SECTION V:

The City Clerk is hereby directed to certify the adoption of this Ordinance and cause a summary of the same to be published as required by law. This Ordinance shall take effect thirty (30) days from the date of adoption.

ADOPTED this ____ day of _____, 2020.

_____
Mark A. Murphy, Mayor, City of Orange

ATTEST:

_____
Pamela Coleman, City Clerk, City of Orange

STATE OF CALIFORNIA)
COUNTY OF ORANGE)
CITY OF ORANGE)

I, PAMELA COLEMAN, City Clerk of the City of Orange, California, do hereby certify that the foregoing Ordinance was introduced at the regular meeting of the City Council held on the ___ day of _____, 2020, and thereafter at the regular meeting of said City Council duly held on the ___ day of _____, 2020 was duly passed and adopted by the following vote, to wit:

AYES: COUNCILMEMBERS:
NOES: COUNCILMEMBERS:
ABSENT: COUNCILMEMBERS:
ABSTAIN: COUNCILMEMBERS:

_____
Pamela Coleman, City Clerk, City of Orange

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

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Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

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2014000535189 9:23 am 12/11/14
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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

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Exhibits

Exhibit "A" Legal Description of the 605 Building Site
Exhibit "B" Resolution No. 9843
Exhibit "C" Legal Description of the City Tower Two Site
Exhibit "D" Public Benefit Fees

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Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

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(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

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(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

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(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

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(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

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(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

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(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

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(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

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City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

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otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

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general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

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certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

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Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

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(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

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Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

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Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

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Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

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Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

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entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

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Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

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23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

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IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

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DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

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ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

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EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

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widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

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ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

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EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

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Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

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Exhibits

Exhibit "A" Legal Description of the 605 Building Site
Exhibit "B" Resolution No. 9843
Exhibit "C" Legal Description of the City Tower Two Site
Exhibit "D" Public Benefit Fees

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Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

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(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

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(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

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(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

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(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

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(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

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(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

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(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

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City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

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otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

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general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

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certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

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Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

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(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

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Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

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Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

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Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

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Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

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entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

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Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

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23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

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IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

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DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

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ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

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EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

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widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

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ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

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EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

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LONG-RANGE STRATEGIC REAL ESTATE PLAN – EXCESS REAL ESTATE: DEVELOPMENT OR DISPOSITION - UPDATE

FINANCE AND AUDIT COMMITTEE MEETING

FEBRUARY 16, 2017

GLEN ALLEN, PRESIDENT

NEWPORT REAL ESTATE SERVICES, INC.

NEWPORT
Real Estate Services, Inc.®

Purpose of Presentation

- CalOptima Staffing Needs
- Review Site Plan
- Review Development Rights Options: Pros/Cons
- Review Development Rights Timeline
- CalOptima Development vs. 3rd Party Disposition

NEWPORT
Real Estate Services, Inc.®

Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

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Needs Assessment - Assumptions

- Optimized Telecommuting
- Assumes Projected Programs
  - Cal-MediConnect
  - Medi-Cal
  - OneCare
  - PCC Program
  - ACA Related and Demographic-Trend Member Growth
- Recapture of all 505 Space
- 1 person/181 s.f. space allocation

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Current Space Projection

505 Building Available Seats	
On Site	749
Filled Seats	46
Sub-Total	**795**
Teleworker/Community	318
Total	**1,114**
Total Space Available	**1,025**
Filled Seats and Temp Help	(795)
Total Vacant Spaces	**257**
Pending Requests to Fill	(142)
Expected Employee Count for New Programs	(26)
Net Space Surplus (Shortfall)	**89**
10th Floor Space	85
Total Surplus (Shortfall)	**174**

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Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

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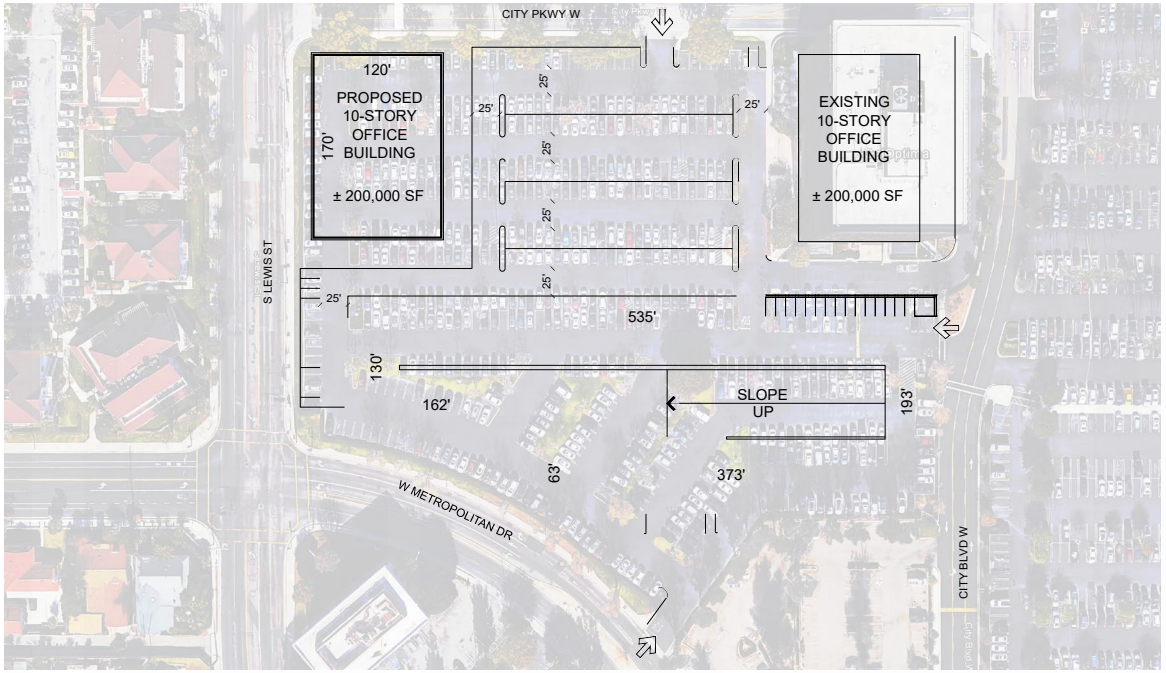
Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

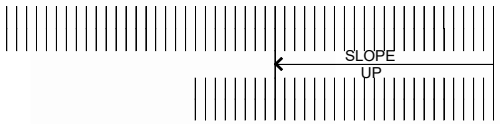
PROPOSED BUILDING: 200,000 SF

TOTAL BUILDING: 400,000 SF

F.A.R.: 1.46

PARKING REQUIRED: 2,000 STALLS
(400,000 SF @ 5/1000)

PARKING PROVIDED: ±2J032 STALLS
SURFACE: 192 STALLS
1ST FLOOR STRUCTURE: 240 STALLS
2-6TH FLOOR STRUCTURE: 1,450 STALLS
(290/STORY, TYP.)
7TH FLOOR: ±150 STALLS



TYPICAL PARKING LEVEL

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Development/Disposition Alternatives

RFP (Already Prepared)
- Direct Sale
- Ground Lease
- Joint Venture
- Trade of Nearby Property
  (Options to Occupy)

CalOptima Development/Construction
- Design/Bid/Build
- Design/Build
- Balance Sheet/Capital Implications
- Vacant Area Risk Assessment

Extend Development Agreement
- City Approval Required
- Fee Payment Likely Required

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Development Alternative Options

		Pros	Cons	Fiscal
Direct Sale:	CalOptima could directly sell the development rights and secure space for CalOptima's use.	1. Large one time capital infusion 2. Reserved right for additional space 3. No development risk	1. Loss of future control 2. Restricted expansion rights 3. Lease payments required on additional space	1. Large, one-time capital event 2. No on-going income 3. Lease payments for additional space
Ground Lease:	CalOptima could lease the property to a developer.	1. Long-term income stream 2. Reserved right for additional space 3. No development risk	1. Loss of future control 2. Restricted expansive rights 3. Lease payments required on additional space	1. Long-term income stream with periodic adjustments 2. Lease payments for additional space
Direct Development:	CalOptima could assign the development rights to a developer, who would provide space back to CalOptima in return.	1. Property is already owned by CalOptima 2. Current Entitlement already in place 3. Multiple delivery/financing options 4. Total flexibility with building design 5. Future expansion space 6. Inclusion of PACE 7. Incorporation of formal board space 8. Eliminate need for offsite leased space	1. Time to delivery: 22-30 months 2. Splits staff to 2 buildings 3. Capital requirement	1. Large capital expenditures for development required 2. No future rent payments 3. No lease payment for additional space 4. Lease income from expansion space tenants
Joint Venture:	CalOptima could develop the property jointly with a developer.	1. Participation in development Upside 2. Reserved right for additional space 3. Reduced development risk	1. Participation in development Downside 2. Some cash flow and development risks 3. No cash flow during development and lease-up period 4. Consistency with CalOptima core mission 5. Market Risk	1. Variable on-going income from project cash flow 2. No large capital contribution required
Exchange for Nearby Property:	CalOptima could exchange the development rights for a developed property	1. Ability to obtain pre-built expansion space 2. Likely "built-in" phased space availability 3. On-going cash flow	1. Market Risk 2. Building operations obligations 3. Value of suitable trade property	1. No large capital outlay 2. On-going income stream

NEWPORT Real Estate Services, Inc.®

Conceptual Development Timeline



NEWPORT
Real Estate Services, Inc.®

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Actions Related to CalOptima's Development Agreement with the City of Orange

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Receive and file the Property and Associated Development Rights Request for Information (RFI) results, dated April 21, 2017, that relate to property covered by CalOptima's existing development agreement at the 505 City Parkway West project site;
2. Authorize the Chief Executive Officer (CEO) to: ~~complete a Request for Proposal (RFP) process to select a real estate development consultant to assist CalOptima in:~~
    a. Contact the City of Orange (City) to explore:
        i. Extending CalOptima's existing development agreement for as long as possible (e.g., through 2026);
        ii. Broadening CalOptima's rights under the development agreement from commercial/office to include urban mixed use, including transitional housing; ~~the current Development Agreement with the City of Orange, which covers an office tower of up to 10 stories and a 1,528 space parking structure~~
    b. After confirming that the City is amenable to the proposed changes: ~~Developing a plan for moving forward with a parking structure~~
        i. Initiate a RFI process on development options for the site assuming the use of no Medi-Cal dollars and including a parking structure;
        ii. Seek assistance from the County of Orange Real Estate (Development Services) Department, as appropriate.
    c. ~~Conducting analysis and making recommendations on permissible options for further development of the site (e.g., Mixed Use, etc.), along with potential costs and funding mechanisms that would be associated with the exercise of each option.~~

Rev. 12/7/17

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to 10 stories and 200,000 square feet of office space, and a parking structure of up to five levels and 1,528 spaces. The office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the 505 City Parkway West building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014, meeting, the CalOptima Board of Directors authorized an amended and restated Development Agreement with the City of Orange to extend CalOptima's development rights for six

years, until October 28, 2020. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. CalOptima agreed to pay a required $200,000 public benefit fee to the City of Orange in exchange for the extension.

In 2016, at its August 4th and December 1st meetings, the Board authorized contracts with real estate consultant Newport Real Estate Services, Inc. to evaluate options for CalOptima's current development rights and to create a site plan. Newport Real Estate Services completed this analysis and presented the requested information to the Board's Finance and Audit Committee (FAC) in February 2017, and FAC recommended that the Board authorize issuance of a Property and Associated Development Rights Request for Information (RFI). The RFI was designed to gauge potential interest in and options for CalOptima's development rights. The Board approved the issuance of an RFI at its March 2, 2017, meeting.

By the close of the RFI response period on April 21, 2017, only one response had been received, from Trammel Crow Company. The RFI was narrowly focused on office space and parking, as per the current Development Agreement. This limited response to the RFI, as well as other informal discussions with industry representatives during the RFI process, may reflect the real estate community's limited level of interest in commercial office space at this time.

Discussion

In the years since the purchase of 505 City Parkway West, CalOptima's membership has grown significantly with the implementation of the Affordable Care Act. And while membership has been essentially stable in 2017, the operational and oversight demands have continued to grow, as have the number of programs the state has folded into the Medi-Cal managed care plans, in large part due to their member focus and cost effectiveness. While approximately 10% of the available 505 building workstations are currently unoccupied, the building is currently fully occupied as this "flex space" is critical to the Facilities Department's efforts to optimize available workspace to maximum workforce productivity (e.g., placing employees in a particular department in the same area/on the same floor of the building).

While CalOptima's existing office tower and employee workspaces are meeting current needs (with nearly one third of the staff in telework positions), it is anticipated that longer term, additional space may be required to meet the organization's needs. In the immediate term, parking is a pressing issue, with available spaces marginally adequate to meet parking needs during peak hours of operations. While management has explored a number of options to reduce the need to parking (e.g., further expansion of the telework program, carpools, vanpools, flexible start times, supporting alternative transportation, etc.), the need for additional parking is an increasingly pressing issue. One approach under consideration would be to recommend development of the parking structure initially, with a decision on the office tower development rights addressed at a later date.

Regarding the potential development of a second ten story office tower at this time, with the assumption that it would at least initially be partially occupied by third parties, various market factors suggest that growth in demand for professional office space by third party tenants in the North Orange County region appears somewhat limited, though in the immediate area, virtually all available commercial space is currently occupied. According to a Second Quarter 2017 analysis by Colliers

International, market activity has slowed compared with the past two years. Staff's understanding is that average lease rates in the North Orange County area remain at approximately $2.23 per square foot, which is below their 2007 peak. Staff also believes that, while there are a number of large developments in the works for central Orange County, the majority of new, large scale professional office projects in the county are proposed within the John Wayne Airport and South Orange County areas as opposed to the North Orange County region. These trends may limit the value of CalOptima's current Development Agreement if the decision is to develop the site as a 10-story commercial building that will, in part, be leased to third parties.

To ensure that a comprehensive review process is completed before a decision is made on the best use of the new tower site, staff is recommending that the Board obtain the expertise of a real estate development consultant to evaluate the potential value of a revised Development Agreement that would allow for other potential uses such as, for example, Urban Mixed-Use zoning, which would include commercial retail and housing uses. While this approach may result in the facility being sold to a third party, it assumes that CalOptima will make other arrangements to meet any increases in need for office space as the current facility is near capacity today. Though it is possible that the commercial vacancy rate in the area may increase in the future, when CalOptima was considering additional space approximately two years ago, very limited space was available within several miles of the 505 building. At this stage, one possible approach the consultant could explore would be to focus on prioritizing the additional parking space now, and either seeking an extension of the remaining rights as further study is completed on the available options, or estimating the cost of seeking a change to the Development Agreement to allow for Mixed Use zoning. Another option would be to sell the rights to a third party who may be interested in exercising the existing development rights, or pursuing a change with the City of Orange.

Fiscal Impact

The FY 2016-17 Board-approved CalOptima Medi-Cal operating budget includes $37,000 for Real Estate Consultant services. In addition to this amount, once the scope of work for the consultant is developed, staff will return to Board with an estimate of additional costs.

California Welfare and Institutions Code section 14087.54, CalOptima's enabling statute, provides that CalOptima was established to "meet the problems of delivery of publicly assisted medical care in the county… and to demonstrate ways of promoting quality care and cost efficiency." The statute also includes provisions limiting the use of "any payment or reserve from the Medi-Cal program" to administration of the Medi-Cal program itself. Consequently, alternative funding (i.e., from a source other than CalOptima) would be an essential element of any recommendation to use the development rights for some purpose not specifically related to CalOptima's administration obligations under the Medi-Cal program.

Rationale for Recommendation

In order to assist the Board in determining next steps with the existing Development Agreement with the City of Orange, staff recommends engaging a real estate consultant.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated March 2, 2017, Consider Options for Development Rights at 505 City Parkway West, Orange, California Site
    a. Amended and Restated Development Agreement dated December 10, 2014
2. Notice of Request for Information #17-031, dated March 20, 2017, Amendment No. 1, for Property and Associated Real Estate Development Rights
3. Response to Request for Information: Property and Associated Real Estate Development Rights, TrammellCrowCompany, dated April 21, 2017
4. California Welfare and Institutions Code section 14087.54

/s/ Michael Schrader — *11/30/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Options for Development Rights at 505 City Parkway West, Orange, California Site

Contact
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO) to issue a Request for Information (RFI) to solicit responses regarding potential interest and options for CalOptima's development rights with results to be presented to the Board at a future date.

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the "605 Building Site." At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the Board authorized the CEO to enter into an Amended and Restated Development Agreement with the City of Orange to extend CalOptima's development rights for up to six additional years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At its August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

At the December 1, 2016 meeting, the Board authorized a contract amendment with real estate consultant, Newport Real Estate Services (NRES), to include site plan development and expenditures from existing reserves of up to $7,000 to fund the contract amendment.

Discussion
At its February 16, 2017 meeting, the Board of Directors' Finance and Audit Committee (FAC) received presentations from CalOptima management and real estate consultant, NRES. The presentation included an update on CalOptima's staffing needs and space alternatives, a review of a site plan developed by NRES, options for exercising the development rights with pros and cons of

certain options, and a preliminary timeline. In addition, FAC members discussed the need to gather more information and to gauge potential interest on the following options: Direct Sale, Ground Lease, Joint Venture, and Property Trade.

An additional option is pursuing an extension of the current Development Agreement for an additional 3 years beyond 2020. This option would require approval by the City of Orange, and would likely require CalOptima to make additional public benefit fee payments. In the event the Board elects to pursue this option, and the City of Orange is agreeable to the extension, Staff will return to the Board to present applicable proposals.

Fiscal Impact
The recommended action to issue an RFI for development rights is budget neutral.

Rationale for Recommendation
The Development Agreement with the City of Orange provides CalOptima the opportunity to provide for future space needs in the event CalOptima requires additional office space. At the same time, the development rights are a valuable asset that can be severed from the existing parcel if CalOptima finds that CalOptima's construction of a separate office building and parking structure is not practical, feasible, or otherwise in the best interest of the organization. Management recommends that the Board authorize the CEO to issue an RFI to fully explore potential interest and options available with the existing development rights.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
2. CalOptima Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
3. NRES PowerPoint Presentation to the Board of Directors' Finance and Audit Committee dated February 16, 2017: Long-Range Strategic Real Estate Plan – Excess Real Estate Development or Disposition Update

/s/ Michael Schrader — *2/23/2017*
Authorized Signature — **Date**

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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

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

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Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

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Exhibits

Exhibit "A" Legal Description of the 605 Building Site
Exhibit "B" Resolution No. 9843
Exhibit "C" Legal Description of the City Tower Two Site
Exhibit "D" Public Benefit Fees

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Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

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(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

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(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

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(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

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(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

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(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

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(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

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(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

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City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

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otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

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general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

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certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

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Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

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(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

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Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

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Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

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Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

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Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

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entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

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Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

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23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

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IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

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DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

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ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

Suzanne M. Turf
Notary Public in and for said State

(SEAL)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

Michele E. Day
Notary Public in and for said State

(SEAL)

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EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

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EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

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RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

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widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

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ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

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EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

LONG-RANGE STRATEGIC REAL ESTATE PLAN – EXCESS REAL ESTATE: DEVELOPMENT OR DISPOSITION - UPDATE

- FINANCE AND AUDIT COMMITTEE MEETING
- FEBRUARY 16, 2017
- GLEN ALLEN, PRESIDENT
- NEWPORT REAL ESTATE SERVICES, INC.

NEWPORT Real Estate Services, Inc.®

Purpose of Presentation

- CalOptima Staffing Needs
- Review Site Plan
- Review Development Rights Options: Pros/Cons
- Review Development Rights Timeline
- CalOptima Development vs. 3rd Party Disposition

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Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

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Needs Assessment - Assumptions

- Optimized Telecommuting
- Assumes Projected Programs
  - Cal-MediConnect
  - Medi-Cal
  - OneCare
  - PCC Program
  - ACA Related and Demographic-Trend Member Growth
- Recapture of all 505 Space
- 1 person/181 s.f. space allocation

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Current Space Projection

505 Building Available Seats	
On Site	749
Filled Seats	46
Sub-Total	**795**
Teleworker/Community	318
Total	**1,114**
Total Space Available	**1,025**
Filled Seats and Temp Help	(795)
Total Vacant Spaces	**257**
Pending Requests to Fill	(142)
Expected Employee Count for New Programs	(26)
Net Space Surplus (Shortfall)	**89**
10th Floor Space	85
Total Surplus (Shortfall)	**174**

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Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

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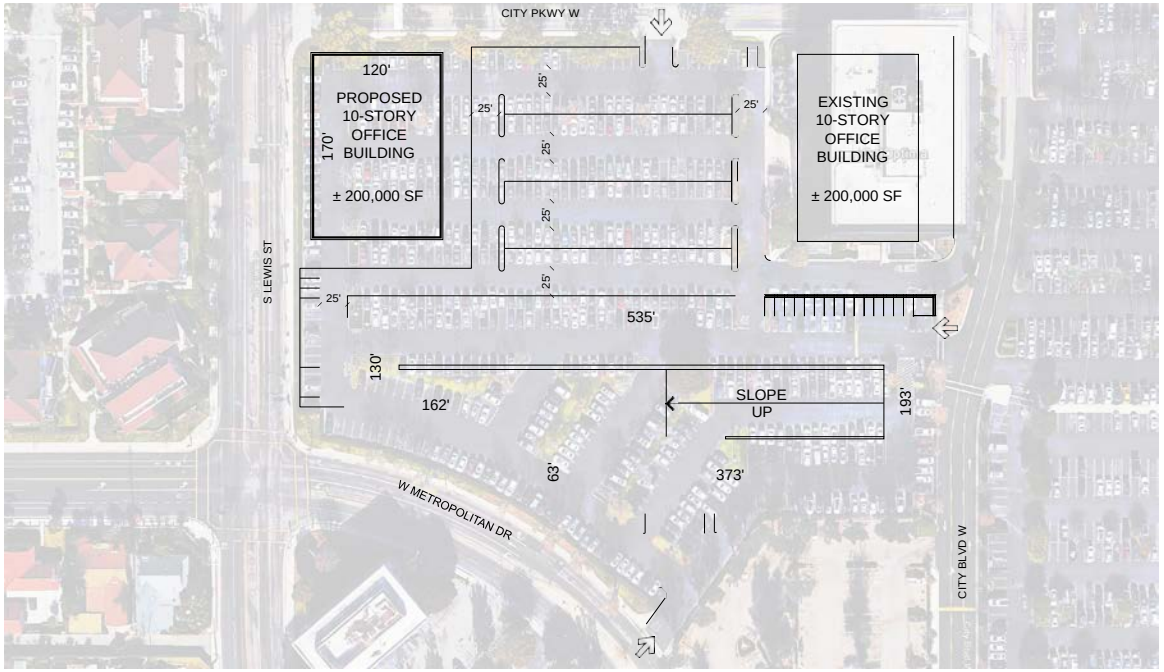
Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

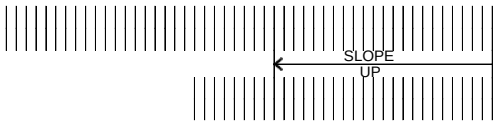
PROPOSED BUILDING: 200,000 SF

TOTAL BUILDING: 400,000 SF

F.A.R.: 1.46

PARKING REQUIRED: 2,000 STALLS
(400,000 SF @ 5/1000)

PARKING PROVIDED: ±2J032 STALLS
- SURFACE: 192 STALLS
- 1ST FLOOR STRUCTURE: 240 STALLS
- 2-6TH FLOOR STRUCTURE: 1,450 STALLS
  (290/STORY, TYP.)
- 7TH FLOOR: ±150 STALLS



TYPICAL PARKING LEVEL

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Development/Disposition Alternatives

RFI (To be Prepared)
- Direct Sale
- Ground Lease
- Joint Venture
- Trade of Nearby Property
  (Options to Occupy)

CalOptima Development/Construction
- Design/Bid/Build
- Design/Build
- Balance Sheet/Capital Implications
- Vacant Area Risk Assessment

Extend Development Agreement
- City Approval Required
- Fee Payment Likely Required

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Development Alternative Options

		Pros	Cons	Fiscal
Direct Sale:	**CalOptima could directly sell the development rights and secure space for CalOptima's use.**	**1. Large one time capital infusion 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansion rights 3. Lease payments required on additional space**	**1. Large, one-time capital event 2. No on-going income 3. Lease payments for additional space**
Ground Lease:	**CalOptima could lease the property to a developer.**	**1. Long-term income stream 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansive rights 3. Lease payments required on additional space**	**1. Long-term income stream with periodic adjustments 2. Lease payments for additional space**
Direct Development:	**CalOptima could assign the development rights to a developer, who would provide space back to CalOptima in return.**	**1. Property is already owned by CalOptima 2. Current Entitlement already in place 3. Multiple delivery/financing options 4. Total flexibility with building design 5. Future expansion space 6. Inclusion of PACE 7. Incorporation of formal board space 8. Eliminate need for offsite leased space**	**1. Time to delivery: 22-30 months 2. Splits staff to 2 buildings 3. Capital requirement**	**1. Large capital expenditures for development required 2. No future rent payments 3. No lease payment for additional space 4. Lease income from expansion space tenants**
Joint Venture:	**CalOptima could develop the property jointly with a developer.**	**1. Participation in development Upside 2. Reserved right for additional space 3. Reduced development risk**	**1. Participation in development Downside 2. Some cash flow and development risks 3. No cash flow during development and lease-up period 4. Consistency with CalOptima core mission 5. Market Risk**	**1. Variable on-going income from project cash flow 2. No large capital contribution required**
Exchange for Nearby Property:	**CalOptima could exchange the development rights for a developed property**	**1. Ability to obtain pre-built expansion space 2. Likely "built-in" phased space availability 3. On-going cash flow**	**1. Market Risk 2. Building operations obligations 3. Value of suitable trade property**	**1. No large capital outlay 2. On-going income stream**

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Conceptual Development Timeline



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CalOptima
Better Together

March 20, 2017

Amendment No.1
NOTICE OF REQUEST FOR INFORMATION (RFI)

#17-031

GENERAL CONDITIONS AND INSTRUCTIONS TO RESPONDENTS

For

PROPERTY AND ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

Key RFI Dates

Written Questions Due: March 30, 2017, 12:00 p.m. Pacific Time
Proposal Submittal Date: April 21, 2017, 12:00 p.m. Pacific Time

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SECTION I: INSTRUCTIONS AND CONDITIONS

1. GENERAL INFORMATION

1.1. The purpose of this Request for Information (RFI) is to seek background information from qualified real estate developers regarding their interest in a potential real estate agreement with regard to CalOptima's Real Estate Development rights located at 605 City Parkway West, Orange, CA 92868.

1.2. THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes to assist CalOptima in finalizing the scope of work and requirements which may be used at a future date in the issuance of a Request for Proposal (RFP). It does not constitute a Request for Proposal (RFP) or a promise to issue an RFP in the future. This request for information does not commit CalOptima to contract for disposition whatsoever. Further, CalOptima is not at this time seeking proposals and will not accept unsolicited proposals. Respondents are advised that CalOptima will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future RFP. If a solicitation is released, it will be released through BidSync. It is the responsibility of the potential Respondent to monitor this site for additional information pertaining to this requirement.

2. POINT OF CONTACT

All communications relating to this RFI must be directed to CalOptima's designated contact below:

Kim Marquez
Senior Buyer
CalOptima Vendor Management Department
Kmarquez2@CalOptima.org

3. QUESTIONS AND CLARIFICATIONS

3.1. If a Respondent desires an explanation or clarification of any kind regarding any provision of this RFI, the Respondent must generate a written request for such explanation or clarification through BidSync by March 30, 2017, 12:00 p.m. Pacific time.

3.2. Inquiries received after March 30, 2017 12:00 p.m. Pacific time will not be responded to. Inquiries received by email to the contact above will not be responded to. All questions should be directed to CalOptima through BidSync.

3.3. CalOptima responses to questions will be communicated via BidSync, and will be sent no later than April 5, 5:00 p.m. Pacific time.

4. RESPONSES

Interested parties are requested to submit their response through BidSync no later than April 21, 2017, 12:00 p.m. Pacific Time. Information submitted outside of Bidsync will not be considered.

5. USE OF RESPONDENT'S RESONSE AND ACCOMPANYING MATERIAL

5.1. All materials submitted become the property of CalOptima and will not be returned. If the Respondent intends to submit confidential or proprietary information as part of its response, any limits on the use or distribution of that material should be clearly delineated in writing. However, CalOptima is a public agency and therefore subject to the California Public Records Act (California Government Code, Section 6250 et seq).

5.2. CalOptima will use reasonable precautions allowed by law to avoid disclosure of the Respondent response. CalOptima reserves the unrestricted right to copy and disseminate the Respondents response for internal review and for review by external advisors, at CalOptima's sole discretion.

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6. INDUSTRY DISCUSSIONS

CalOptima representatives may or may not choose to meet with Respondents. Such discussions would only be intended to get further clarification of potential capability to meet the requirements.

7. SUMMARY

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY to identify available opportunities in the market as well as resources that can provide information regarding the CalOptima Real Estate Development rights. The information provided in the RFI is subject to change and is not binding on CalOptima. CalOptima has not made a commitment to contract for any of the items discussed, and release of this RFI should not be construed as such a commitment. All submissions become CalOptima property and will not be returned.

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SECTION II: CALOPTIMA BACKGROUND AND OVERVIEW

1. County Organized Health Systems (COHS) Background

The California State Medicaid (Medi-Cal) program came into existence in March 1966 as a fee-for-service health care delivery system. In May 1972, Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary and limited to those in a public assistance aid category.

In June 1983, a new type of managed care program, the County Organized Health System (COHS), became operational. The COHS managed care model ensures Med-Cal recipients access to comprehensive, cost-effective health care. Each COHS plan is sanctioned by the County Board of Supervisors and governed by an independent commission.

2. CalOptima Overview

CalOptima's Overview can be located by clicking on the following link and by selecting 'View CalOptima Fast Facts": https://www.caloptima.org/AboutUs.aspx

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SECTION III: GENERAL REQUIREMENTS

1. BUSINESS OBJECTIVES/TIMING

CalOptima is considering monetizing the additional available land and entitlement rights located adjacent to its headquarters building located at 505 City Parkway West, Orange, California. CalOptima has the following key objectives:

1.1. Monetizing this asset while the development rights are still available;

1.2. Providing for potential additional expansion space to meet CalOptima's chartered goals and objectives.

While CalOptima has the ability and resources to develop the parcel internally, there may be significant advantages to having this development be completed through a sale (with leaseback opportunities), joint venture or other financial structure with a third-party.

The primary objective of this RFI is to begin to collect information on third parties that may be potentially interested in acquiring, joint venturing, trading or otherwise assist CalOptima in monetizing this asset.

While no particular timeframe has been established, the initial goal would be to enter into an agreement with a third-party that would allow for the development and construction of the building before expiration of the development rights in October, 2020.

As one of CalOptima's stated goals is to provide for the potential expansion of its workforce in furtherance of its core mission, and development rights for an additional office building are currently in place, CalOptima will only consider expressions of interest, and ultimately development of a class A office building of a type that is similar in quality and configuration to its existing 505 Building. Parties interested in land-use conversion (i.e. apartments or high density residential) should not respond to this RFI, as any such proposed uses will be dismissed without comment.

2. PROJECT OVERVIEW/BACKGROUND

CalOptima acquired the real estate development rights in 2014. The original development of the property site contemplated future construction of an additional 10 story 200,000 SF building to be known as 605 City Parkway West, Orange, CA, as well as an adjacent parking structure, which would accommodate both 505 and 605 buildings.

The objective of this RFI is to collect information from potential interested parties that might help CalOptima achieve these goals.

CalOptima is willing to consider a variety of potential real estate transaction structures. Responders are encouraged to address each of the alternatives outlined below. CalOptima does not, at this time, have a preferred structure. CalOptima will evaluate each of the responses in the interest of obtaining the greatest economic and intrinsic benefit to CalOptima. Respondents are also encouraged to propose alternative ideas that may be of interest to CalOptima.

CalOptima predicts that it may need additional space beyond its corporate headquarters, over time. As such, a continuing right, but not the obligation, to occupy space in the future building to be constructed by Offeror on the Excess Land may be of significant interest to CalOptima.

3. Considerations

3.1. Direct Fee Purchase: CalOptima may consider a direct fee purchase of the Excess Land and associated entitlements. Respondent's proposal for this approach must include estimates of

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proposed purchase price, transaction timing, and other general provisions of Respondent's proposal.

3.2. Ground Lease/Participating Ground Lease: CalOptima may consider a ground lease of the Excess Land. In the case of a ground lease, or participating ground lease proposal, the Offeror should include an estimated initial base rent, lease term and lease payment commencement, proposed escalation, ground lease term, subordination (an unsubordinated ground lease is strongly preferred), and other general terms of the ground lease/participating ground lease. In the event Offeror proposes a participating ground lease, Offeror's proposal should include minimum rent, percentage participating, formula and basis for participation as well as the other terms addressed in the fixed ground lease proposal.

3.3. Joint Venture: While a joint venture between a private-sector entity and a public agency does present its challenges, CalOptima wants to remain flexible with regard to potential transaction structures that may enhance cash flow, flexibility and overall economic benefit for the agency. Respondents proposing a joint venture structure should address joint venture structure preferential rates of return, capital contribution values, distribution priorities and capital risk exposure. Please keep in mind that CalOptima will require that its equity value be in first priority and not subject to foreclosure risk.

3.4. Potential Trade: As part of its mandated healthcare delivery mission for the residents of Orange County, CalOptima anticipates that its staffing levels may continue to increase over the coming years. While CalOptima does not occupy all of the current building, it anticipates that as a space in the building is recaptured, its space needs may exceed the capacity of the current building. As such, acquisition of a nearby, preferably, adjacent building may be of interest to CalOptima. Respondents that currently own a nearby building may want to consider proposing a trade of the Excess Land for such a building. Respondents considering this approach should address: the location and physical condition of the trade property, any existing leases or other restrictions on occupancy, building condition, and terms of trade.

4. Highlights of CalOptima's Development Rights Agreement

4.1. Development Agreement

a. Rights for development of the "605 Building" and related parking structure. Development rights for the referenced City Plaza Two Site were subsequently assigned to another developer (see Estoppel Certificate).

b. Section 1(j)(2)(B) - CUP for 605 Building site (approved by City Council 10/9/01) – 10 story, 200,000 SF building and a 5-level, 1,528 space parking structure.

c. Section 1(j)(3)-(6) – Cost sharing with other projects for area traffic improvements and widening of Orangewood Avenue bridge over the Santa Ana River (should be no exposure to such costs if development does not occur at the 605 Building site).

d. Section 7(e) – Good Faith Efforts Regarding Block of Orange Expansion – Mentions CC&R's of "The City" (to be further researched).

e. Section 12 – Term expires 10/28/19.

f. Section 14(a) – Covers assignment for a portion of the project sold; requires 30 day notification by Seller and Purchaser is to agree in writing to be subject to terms of the Agreement.

g. Section 14(b) – Reference is made to responsibility for reporting and annual review requirements (to clarify).

h. Public Benefit Fees. Fees would have needed to be paid in order to keep the Agreement active, including library and park related fees.

a. Prior to obtaining a certificate of occupancy, separate $25,000 fees would be required for two City of Orange Foundations.

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4.2. First Amendment to Development Agreement – Executed 1/20/06:

a. Public Benefit Fees Payable - $15,000 of a $100,000 Park Fee to be paid within two business days of receiving a building permit for the 605 Building.

4.3. Second Amendment to Development Agreement

a. Amended Exhibit D is provided for, with remaining applicable fees being as follows

1. $15,000 Library Fee (15% of $100,000) and $15,000 Park Fee (15% of $100,000) within two business days of receiving a building permit for the 605 Building.

2. If the Agreement has not been terminated and an agreement has not been reached with the Block owner regarding certain elements of the proposed Block expansion, prior to obtaining a certificate of occupancy, separate $25,000 fees would be required for two City of Orange Foundations; and

3. Commencing on the Second Resolution Effective Date (5/30/07) and each anniversary thereof, continuing through the initial term (10/28/14), a $30,000 fee is required.

4.4. Operating Memorandum – Executed 1/22/07:

a. Block expansion plans were modified and CC&R's were amended by Block ownership and the City Parkway ownership at the time.

b. City Parkway owner relieved of any or all of the Public Benefit Fees.

4.5. Estoppel Certificate – Provided by City of Orange to the Current Ownership, 5/13/09:

a. Indicates Maguire assigned its rights to the City Plaza Two Site in August 2008 to HFOP City Plaza, LLC.

b. Acknowledges there were no Public Benefit Fees or other development, traffic mitigation or processing fees due from Maguire (seller) at that time.

c. Certificate shall inure to the benefit of Purchaser, Lender and their respective successors and assigns.

4.6. Conditional Use Permit – Resolution No. PC 19-01 (as referenced in Section 1(j)(2)(B) of the Development Agreement):

a. Approval for a 10-story, 200,000 SF office building and 5-level, 1,528 space parking structure, subject to several conditions and mitigation measures outlined in the CUP.

5. SUGGESTED CONTENT OF RESPONSE

CalOptima is asking interested Respondents to submit a response containing, at a minimum, the following information.

5.1. General Respondents Information

a. Explain the reason for your firm's interest in possibility providing the services listed within this RFI.

b. Name and contact information of person we can contact if we have questions.

c. Brief history of your firm.

d. Brief description of past experience providing similar services.

5.2. Additional Questions

a. Provide any comments, observations or suggestions which may assist CalOptima in drafting a procurement solicitation.

b. Please provide a brief summary of how you might envision the transaction structures that your firm would propose.

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c. If possible, please provide preliminary economic results of how you might see a transaction being structured.

d. Please provide a potential timeline for any of the structures that you believe might be appropriate for your firm.

e. Please outline the obligations that your firm would request of CalOptima as part of any transaction structure.

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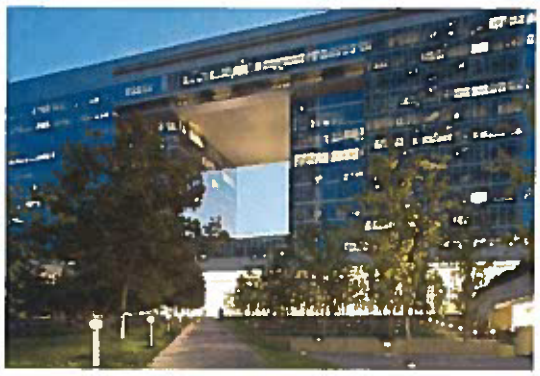
RESPONSE TO REQUEST FOR INFORMATION:

PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS

605 CITY PARKWAY WEST, ORANGE, CA









PRESENTED TO:

CalOptima
A Public Agency
Better. Together.

PRESENTED BY:

Trammell Crow Company

APRIL 21, 2017

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Tom Bak
Senior Managing Director
Trammell Crow Company
Development and Investment

Trammell Crow Company

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Newport Beach, California 92660

Work: 949.477.4702
Fax: 949.477.9107

tbak@trammellcrow.com
www.trammellcrow.com

April 21, 2017

Ms. Kim Marquez
Senior Buyer
CalOptima Vendor Management Department
505 City Parkway West
Orange, CA 92868

RE: Response to RFI for Property & Associated Real Estate Development Rights at 605 City Parkway West

Dear Ms. Marquez:

We are pleased to formally provide this Response to Request for Information for the Property and Associated Real Estate Development Rights located at 605 City Parkway West in the City of Orange.

The Trammell Crow Company is widely recognized as the Nation's largest developer by total product under construction, and has been ranked #1 for the past three consecutive years in Commercial Property Executive Magazine's 2014, 2015, & 2016 list of national developers. The proposed team highlighted in this proposal offers local Class A Office Development experience backed by a nationally renowned organization.

In the pages that follow, you will find a detailed response that seeks to emphasize the following key elements that we believe position our team to provide CalOptima with the highest level of service and certainty of performance:

Local Presence & Experience: Trammell Crow Company has had a strong presence in Southern California since 1972. Our SoCal team is currently comprised of 28 real estate professionals who cover Orange County, Los Angeles, San Diego, and the Inland Empire. Over the last few years, while many of our competitors have disappeared, our balanced business model combining development with acquisitions has allowed us to thrive and gain substantial market share. Our Southern California team has experience building and entitling well over 100 projects across class "A" office, healthcare, industrial, retail, mixed use, and residential product types.

Office Development Expertise: Trammell Crow Company's Southern California Development & Investment team has an established reputation in Class-A office development, with individuals who dedicate their entire practice to the successful execution of office projects, specifically development and leasing. In just the past ten years, we have developed a diverse array of office product, including speculative, build-to-suit, ground-up and redevelopment, totaling 1.9M SF and valued at over $1.3 billion.

Public Agency & Government Collaboration: Our Team has a proven track record of successfully working with local governments on the acquisition, ground-leasing, development, planning, construction, leasing, and property management of office buildings leased to public agencies and governmental tenants. We are also experts in developing strategies for designing, financing and constructing projects that serve as sources of economic development for the surrounding community. These buildings are compelling places to work as well as sources of community identity and renewal.

Our team offers extensive Southern California development experience, a strong history of partnerships with governmental clients, design-build expertise, ability to independently finance the project, and, most importantly, a culture of honesty and dedication with a commitment to exceeding client expectations. We greatly appreciate your consideration and the opportunity to work with CalOptima on this exciting piece of property. We look forward to meeting with you to discuss our proposal. If you have any questions regarding the attached proposal, please do not hesitate to contact me.

Warm regards,

Tom Bak
Senior Managing Director

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PROPERTY & ASSOCIATED REAL ESTATE DEVELOPMENT RIGHTS
605 CITY PARKWAY WEST, ORANGE, CA

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SECTION 2 - Additional Questions — Page 20



Trammell Crow Company

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SECTION 1. GENERAL RESPONDENTS INFORMATION

A. EXPLAIN THE REASON FOR YOUR FIRM'S INTEREST IN POSSIBILITY PROVIDING THE SERVICES LISTED WITHIN THIS RFI.

Since 1948, Trammell Crow Company (TCC) has consistently been viewed as a leader and innovator within the real estate development industry. The organization has built it's reputation by focusing on building the best product in the best location. Our Southern California Business Unit has been continually developing successful Class A office product on both a build-to-suit and speculative basis, throughout each of the past ten years, totaling the successful delivery and leasing of over 1.35M SF of office space since 2007, with another 550K SF on track to be completed later this year.

TCC has a long, successful reputation of development within Orange County, and is extremely bullish on this market. We are currently under construction on the largest speculative ground up office development in Southern California. As such, we are in contact with every tenant in the market that is looking for new, high quality work space. We view this as a tremendous opportunity to deliver Class-A office product to the Central County marketplace due to the asset's:

Premier Location: The subject property's premier location in the heart of the City of Orange, adjacent to existing Class A office product, and a surplus of amenities within walking distance makes this an ideal opportunity to provide the newest product to Central Orange County. TCC previously developed the Arena Corporate Center, a 385,000 SF nearby Class A office park, with significant success and has actively been searching for another opportunity in the sub-market.

In-Place Entitlements: The existing entitlements for the project offer a tremendous opportunity to deliver high quality space in a market that has seen minimal development in the past several years. Speed to market is essential in satisfying the needs of tenants in search of space.

We are confident that not only does this particular property offer tremendous potential to satisfy the needs of Orange County's tenant base, but TCC is the ideal group to strategically position, design, develop, and lease this excellent asset with a reputation of:

Successful Collaboration & Partnership with Public Agencies: TCC has worked with numerous governmental and public agencies to entitle, finance, design, and develop numerous Class-A projects throughout Southern California. As detailed in the following case studies, in the past 10 years alone, the TCC Southern California team has successfully completed five built-to-suit office projects, totaling approximately 600,000 SF, and is nearing start of construction on a 200,000 SF, highly customized Medical Office Building for the County of Riverside.

Consistent On-time & On-budget Deliveries: Whether CalOptima determines a need for additional space, or the entire building is ultimately marketed to the outside community, every tenant depends upon a reliable budget and schedule. TCC has a proven track record for delivering projects on-time and on-budget, resulting in consistent repeat business with our clients.





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B. Name and contact information of person we can contact if we have questions.

Profiles for the primary members of the development team that would be dedicated to this project are included on the following pages. David Nazaryk , Managing Director, will serve as Primary Point of Contact.

DEVELOPMENT TEAM



PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
2000 Avenue of the Stars
Arena Corporate Centre
Pacific Vista
Kendall Healthcare BTS
Burbank Airport Plaza
Main Street District Center
California Palms Business Center
Sycamore Business Park
Knox Logistics Center
1-215 Logistics Center
Westec BTS
Centrepointe Chino I
Gateway Diamond Bar
Harman International Campus
Irwindale Business Center I
Irwindale Business Center II
Centrepointe Chino II

TOM BAK
SENIOR MANAGING DIRECTOR
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4702
tbak@trammellcrow.com

Tom Bak is Senior Managing Director of Trammell Crow Company where he serves as a member of the firm's Operating Committee and as a subject matter expert for the National Investment Committee. In his capacity as Senior Managing Director, Tom is responsible for raising capital, setting investment strategy, creating deal flow, negotiating and structuring transactions, advising on financing, asset management and property-related issues, and overseeing the day to day activities of Trammell Crow's Southern California Development & Investment professionals.

EXPERIENCE

Under Tom's leadership, the Southern California Development & Investment Group has completed, or is in the process of completing, the acquisition and development of office, industrial and brownfield projects totaling over 20 million square feet and representing investments of over $1.5 billion from public and corporate pension funds, insurance companies, REITs, Taft Hartley funds, endowments and high net worth partners.

Tom began his career with Trammell Crow Company as a leasing agent. He has received numerous regional and national awards recognizing his achievements as a top leasing and development producer. In 1989, he became one of the youngest partners in the firm. In 1996, Tom became leader of the Southern California Development & Investment Group.

EDUCATION & CREDENTIALS

University of California Los Angeles, MBA
Amherst College, B.A.

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Past President, National Association of Industrial and Office Properties (NAIOP) - Los Angeles Chapter
NAIOP I.CON Conference Speaker, Industrial Trends
University of California - Irvine, Center for Real Estate Advisory Board
Urban Land Institute Conference Speaker, Office Building Design Trends
Pension Real Estate Association (PREA), Developer Affinity Group
St. Joseph Hospital, Planning and Community Benefits Committees

Trammell Crow Company

DEVELOPMENT TEAM (PRIMARY POINT OF CONTACT)



DAVID NAZARYK
MANAGING DIRECTOR
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4732
DNAZARYK@TRAMMELLCROW.COM

David has developed much of TCC's portfolio in Southern California since joining the company in 1996. He also manages the operations of the group. He is responsible for sourcing, underwriting, financing and developing office and industrial projects throughout the Southern California region.

Through his relationships with the brokerage network, governmental officials and capital partners, David has seamlessly and successfully completed some of the largest and most complicated projects within the TCC national portfolio. He has structured and documented numerous development projects with TCC's existing investment relationships and has forged new ones for the company. He is also highly regarded in the company for his unique ability to craft and execute complicated built-to-suit projects. His reputation is one of over-delivering on his promise and providing maximum returns on a variety of real estate development projects. His efforts have been recognized locally and nationally by colleagues through NAIOP Best Project, San Gabriel Valley Best Developer and numerous other awards.

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
2000 Avenue of the Stars
Arena Corporate Centre
Pacific Vista
Kendall Healthcare BTS
Westec BTS
Centrepointe Chino I
Gateway Diamond Bar
Harman International Campus
Irwindale Business Center I
Irwindale Business Center II
Centrepointe Chino II
Burbank Airport Plaza
Main Street District Center
California Palms Business Center
Sycamore Business Park
Innovation Village Research Park
Knox Logistics Center
I-215 Logistics Center

EXPERIENCE

Trammell Crow Company – Southern California– 1996 to Present
Managing Director

- Successfully master planned 10,600,000 SF and developed 6,000,000 SF of office and industrial projects throughout Southern California.
- Established land use designs and/or development plans through selecting, supervising and directing required consultants.
- Negotiates with cities and other governmental agencies to obtain appropriate development mix, entitlements, and land use design standards.
- Effectively markets specific projects such as land, speculative development or build-to-suit, for lease or sale.
- Coordinates all stages of off-site and on-site construction, including tentative and final parcel maps, infrastructure and utility drawings, street and utility construction, preliminary building site plans or office floor plans, working drawings, permit process, construction bidding, on-site shell and tenant improvement construction, Certificate of Occupancy and punch-list completion.
- Provides value engineering through construction experience and local consultant expertise.

Catellus Development Corporation – 1983 to 1996
Project Director

EDUCATION & CREDENTIALS

Evangel College, Springfield, MO, B.A., 1983

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Board of Directors, American Red Cross
Member, National Association of Industrial and Office Properties
Member, Urban Land Institute

Trammell Crow Company

DEVELOPMENT TEAM



MATT CRAMER
SENIOR VICE PRESIDENT
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4735
mcramer@trammellcrow.com

Matt is a recognized industry leader in office product and often lends his expertise to other TCC business units. Matt's strengths include deal underwriting, securing of entitlements, comprehensive development management, pre-construction programming, design-build and construction management. His career path has included various positions from project superintendent to development manager and he is known for his ability to manage and execute difficult projects on time and on budget.

Matt brings more than 25 years of development and construction expertise to Trammell Crow Company. During his career, he has managed development and/or construction of over 9,000,000 square feet of office buildings, parking structures, mixed-use projects, industrial buildings, high tech facilities and public facilities, ranging from $5 million to over $300 million from conception to project completion. Matt is a recognized industry leader in office product and often lends his expertise to other TCC business units. Matt's strengths include deal underwriting, securing of entitlements, comprehensive development management, pre-construction programming, design-build and construction management. His career path has included various positions from project superintendent to development manager and he is known for his ability to manage and execute difficult projects on time and on budget.

PROJECT DEVELOPMENTS

The Boardwalk
County Law Building
Gateway at Alhambra
Innovation Village Research Park
Phase 3, 4, & 5
Washington Mutual Irvine
Office Expansion
Opus Center Irvine Phase I & II
Fairway Center II
Summit Phase I
Westec Orange County
Communications
Galaxy Latin America
Cabot, Cabot & Forbes
Corporate Center
South Coast Metro Center
I-215 Amazon BTS
Amazon Fulfillment Center
Redlands Business Park
Magnolia Point

EXPERIENCE

Trammell Crow Company – Newport Beach, CA – 2005 to Present
Senior Vice President, Development Management

Howard S. Wright Construction Company – 2003 to 2005
Project Executive/Business Unit Manager

Opus West Construction Corporation – 1998 to 2003
Senior Project Manager

L.E. Wentz Company – 1997 to 1998
Senior Project Manager

ARB, Inc. – 1995 to 1997
Project Manager

Turner Construction Company – 1987 to 1995
Project Superintendent

EDUCATION & CREDENTIALS

California State University, Long Beach, B.S., Construction Management

PROFESSIONAL AFFILIATIONS/COMMUNITY INVOLVEMENT

Member, NAIOP, SoCal and Inland Empire chapters
Advisory Council Member, California State University Long Beach School of Engineering
Member, Trammell Crow Company National LEED® "Green Task Force"
State of CA Registered Disaster Service Worker, OES Certified Safety Assessment Volunteer
Step Up On Second Charitable Organization, Past Chairman, Board of Directors

Trammell Crow Company

DEVELOPMENT TEAM



PROJECT DEVELOPMENTS

The Boardwalk

County Law Building

Gateway at Alhambra

Ontario Innovation Center I & II

Knox Logistics Center

1-215 Logistics Center

Magnolia Point

Innovation Village 5

CHRIS TIPRE
SENIOR VICE PRESIDENT
3501 Jamboree Road, Suite 230
Newport Beach, California 92660
O: 949.477.4717
ctipre@trammellcrow.com

Chris serves as Senior Vice President for Trammell Crow Company's Southern California Business Unit in Newport Beach, California. He is responsible for land and deal sourcing, financial analysis, due diligence, entitlements, capital relationships, development coordination, and project marketing and leasing.

EXPERIENCE

Trammell Crow Company – Newport Beach, CA – 2011 to Present
Senior Vice President

- Responsible for management of finance, marketing, leasing, development and operations of 545K SF Class A speculative office development.
- Performs detailed and customized underwriting as primary analyst for all office and industrial acquisitions
- Prepares comprehensive investment summaries with asset and market level analyses for presentation to internal investment committee and institutional investment partners
- Works alongside capital partners, brokers, tenant representatives and prospective investors to analyze new opportunities

LBA Realty – Irvine, CA – 2011
Asset Management Intern

- Assisted in the valuation and management of a $4B portfolio of office and industrial assets

Terranomics Retail Services – Burlingame, CA – 2007 to 2008
Retail Commercial Real Estate Specialist

- Represented Fortune 500 and regional tenants to establish expansion plans, select locations, and negotiate leases in prime retail space
- Managed the leasing of over 2M SF of Power Centers and Grocery anchored shopping center space

Sotheby's International Realty – Santa Barbara, CA – 2006 to 2007
Residential Real Estate Agent

EDUCATION & CREDENTIALS

UC Irvine Merage School of Business, MBA, Real Estate & Finance
UC Santa Barbara, BA, Business & Economics with Emphasis in Accounting

PROFESSIONAL AFFILIATIONS & COMMUNITY INVOLVEMENT

NAIOP – SoCal Chapter
NAIOP – SoCal YPG Alumni
LEED® AP BD+C

Trammell Crow Company

C. Brief History of your firm.

National Experience

Trammell Crow Company (TCC), founded in 1948 in Dallas, Texas, is one of the nation's leading developers and investors in real estate. The company has developed or acquired 2,600 buildings valued at $60 billion and over 565 million square feet. TCC's teams are dedicated to building value for its clients with professionals in 16 major cities throughout the United States. The company serves users of, and investors in office, industrial, retail, healthcare, multi-family residential, mixed use projects, higher education, and airport facilities. For those who occupy real estate, TCC can execute the development or acquisition of facilities tailored to meet its clients' needs. For investor clients, the company specializes in joint venture speculative development, acquisition/re-development ventures, build-to-suit development or providing incentive-based fee development services.

TCC is an independently operated subsidiary of CBRE Group, Inc. (NYSE:CBG), a publicly traded, Fortune 500 and S&P 500 company headquartered in Los Angeles, California. CBRE is the world's largest commercial real estate services and investment firm (in terms of 2016 revenue). For more information visit www.TrammellCrow.com.

Local Expertise

Since TCC's Southern California Development and Investment Group (SoCal D&I) opened in 1972, our team has developed over 100 office, industrial, retail, healthcare, and mixed use projects totaling more than 35 million square feet throughout Los Angeles, Orange, San Bernardino, Riverside, San Joaquin and San Diego Counties. Our Southern California team of 28 professionals is consistently ranked as a "Top Tier" developer and is known for consistently creating the right product in the right market.

Over the past fifteen years, SoCal D&I has built, or is in the process of building, 45 projects comprised of 115 buildings, totaling more than 18 million square feet of office, retail, and industrial product on nearly 1,000 acres of land with costs eclipsing $2.0 Billion. Our team includes in-house environmental expertise through EASI, a division dedicated to managing and mitigating environmental impacts and risks on all new developments. We have worked with numerous cities and municipalities throughout California including, but not limited to Alhambra, Anaheim, Century City, Corona, County of Riverside, Diamond Bar, Fontana, Indio, Irvine, Irwindale, Lake Forest, Los Angeles, Moreno Valley, Pasadena, Redlands, Riverside, and Tracy. Our Team has a proven track record of land acquisitions, ground-leasing, development, planning, construction, leasing, and property management of office buildings. Our experience in each of these areas is demonstrated by the projects outlined herein.

ONE OF THE NATION'S LEADING DEVELOPERS AND INVESTORS IN COMMERCIAL REAL ESTATE

TCC DEVELOPMENT

As of 4Q 2016

Development in Process	$6.5B
Pipeline	$4.1B
Operating	$0.2B
TOTAL	$10.8B

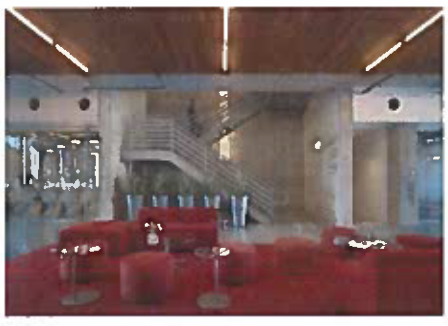
MERITS

#1 Top Development Firm Commercial Property Executive National 2014, 2015 & 2016

#1 Development Company 2014 & 2015
Modern Healthcare Magazine's Design and Construction Survey

$2.6B in construction starts in 2016







D. Brief description of past experience providing similar services.

The following case studies highlight the TCC SoCal Business Unit's range of experience and expertise across a range of office development product, including speculative, build-to-suit, ground up, and redevelopment.

COUNTY LAW BUILDING - INDIO, CA



PROJECT:	**COUNTY LAW BUILDING**
LOCATION:	Indio, CA
COMPLETION DATE:	December 2014, On Time and Under Budget
REFERENCE:	Stephen Gilbert, Development Manager, Riverside County EDA, (951) 955-4824
PROJECT TYPE:	Class A Office, Governmental Agency Build-to-Suit
SQUARE FOOTAGE:	90,000 SF
PROJECT SUMMARY:	In November 2012, Trammell Crow Company's Southern California Business Unit was selected by the County of Riverside Economic Development Agency as Developer to design, entitle, and construct a state of the art County Law Building in the City of Indio, CA. The new building consolidated multiple County legal departments into a single facility adjacent to the Larsen Courthouse. Located at the prominent corner of Highway 111 and Jackson Street, the Class-A, three story structure creates a focal point at the justice center complex in the midst of its revitalization. The 90,000 SF steel frame building takes advantage of a uniquely shaped site, addressing security and offering multiple access points to separate the public from employee and security oriented vehicle traffic. The building program resulted in the Family Justice Center and the Victim Witness functions occupying 55,000 SF, the Public Defender occupying 24,500 SF, the County Counsel 1,400 SF and the County Law Library 9,450 SF. A future freestanding 5,000 SF retail building will serve the law building and the adjacent community. The project is designed to provide a variety of passive people places both inside and out, including a generous entry plaza complete with an attractive water feature and public art sculpture, shaded outdoor seating and generously landscaped spaces. Through strategic planning, the design team was able to introduce multiple sustainable features including extensive sun shading devices, drought tolerant landscaping, on-site storm drain water retention while recharging the local ground water system, electric vehicle charging stations, photovoltaic parking shade structures, recycled content, low-emitting building materials and many other solutions that have resulted in the project receiving a LEED® Platinum Certification. The project was delivered ahead of schedule and $4M under budget.

GATEWAY AT ALHAMBRA - ALHAMBRA, CA



PROJECT: **GATEWAY AT ALHAMBRA**

LOCATION: Alhambra, CA

COMPLETION DATE: September 2012, On Time and Under Budget

REFERENCE: Jeffrey Siebens, Assistant Director Construction Management, Community Development Commission, County of Los Angeles (626) 586-1792

PROJECT TYPE: Class A Office, Redevelopment, Governmental Agency Build-to-Suit

SQUARE FOOTAGE: 118,265 SF

PROJECT SUMMARY: In August 2010, the Trammell Crow Company's Southern California Business Unit was selected by the National Development Council and the Community Development Commission of the County of Los Angeles (LACDC) as the Developer to design, entitle and construct a state of the art office building for the LACDC. The Gateway at Alhambra was developed in an urban area, where the supply of land is severely constrained. The project development required the demolition of an existing theatre and renovation of an existing parking structure. By selecting a site that could utilize an existing structure, the project was guaranteed sufficient parking, and benefitted from decreased construction time and costs.

The Build-to-Suit office building consolidated two County entities, The Community Development Commission and the Housing Authority, previously located in three separate facilities into a single location. A requirement of the project was to integrate three different and distinct user groups into one building environment. As a redevelopment with an existing parking structure, the building ended up occupying nearly the entirety of the remaining site and the resulting space planning was integrated into a non-typical building site plan.

As a result of extremely efficient design and a collaborative space planning effort by all project constituents, TCC and the project architect were able to reduce the County's original space requirement from 155K SF down to 118K SF, a reduction of nearly 20%, resulting in a significant overall savings in project costs. As part of the project requirements the Community Development Commission required a LEED Silver certification level from the USGBC with the goal of developing a highly sustainable project that would conserve energy, water and non-renewable natural resources while creating a healthier and more comfortable work environment for the Commission and Housing Authority employees. Through strategic planning, the project far exceeded the Community Development Commissions goals as the project ultimately achieved LEED Gold certification.

USC HEALTH SCIENCES BUILDING - LOS ANGELES, CA



PROJECT:	**USC HEALTH SCIENCES BUILDING**
LOCATION:	Los Angeles, CA
COMPLETION DATE:	August 2011, On Time and Under Budget
REFERENCE:	Kristina Raspe, Director, Real Estate and Facilities - Apple, (408) 862-7099
PROJECT TYPE:	Class A Office, Institutional Build-to-Suit
SQUARE FOOTAGE:	120,000 SF
PROJECT SUMMARY:	Trammell Crow Company was selected by the University of Southern California, from a pool of 17 development teams, to ground lease a 5.3 acre property adjacent to the University's Health Science Campus in downtown Los Angeles, create a financing structure to execute the project, and then develop a 120,000 SF administrative office building, which USC would lease back on a concurrent 20 year lease term. To provide USC with a turnkey building, Trammell Crow Company stepped in to manage the programming, design and layout, construction and FF&E delivery of the administrative office, classroom, fitness center and café space. This entailed consolidating 13 different users from all over the USC Los Angeles portfolio into a singular building, while maintaining the specific academic needs of each user group. The project was a resounding success, opening its doors on August 2011 to an onslaught of incoming students ready for their first day of the school year. The project was 4.5 months ahead of USC's required schedule and $2M under budget..

INNOVATION VILLAGE RESEARCH PARK - POMONA, CA



PROJECT:	**INNOVATION VILLAGE RESEARCH PARK AT CAL POLY POMONA**
LOCATION:	Pomona, CA
COMPLETION DATE:	2007, June 2011, December 2015, On Time and Under Budget
REFERENCE:	Sandra Vaughan-Acton, Director of RE Development, Cal Poly Pomona Foundation, Inc. (909) 869-3154
PROJECT TYPE:	Master Planned Class A Office Park, Speculative & Build-to-Suit
SQUARE FOOTAGE:	369,000 SF
PROJECT SUMMARY:	Trammell Crow Company and Cal Poly Pomona University entered into a public/private venture to create a Research Park on its campus. The mission of the partnership was to create an environment in which the business community and the University could interact and collaborate with one another by offering internships to students, job opportunities for graduating students, support of campus programs, etc. TCC and Cal Poly worked together to refine a Master Plan for the remaining 65 acre master planned development with the goal of utilizing additional development opportunities for Build-to-Suits, on-campus academic and student housing facilities. Early in the process it was determined that modern 3-story tilt-up concrete buildings would be the most cost effective construction solution for the product type that was identified to meet the demand in the marketplace. Efficient 40,000 SF floor plates containing a core for each floor with two elevators and adequate restrooms offered flexibility for a wide variety of users, including corporate headquarters, back office, and multi-tenant spaces. The work environment was enhanced by the inclusion of lush landscaping, large people places for relaxation, lunches and outdoor work space, as well as extensive sustainable design features for energy savings, renewable energy, recycled materials, drought tolerant landscaping and water retention resulting in recharging the local groundwater system. Innovation Village Phase 3 commenced as a speculative development by TCC, however Southern California Edison (SCE) was soon identified as a tenant for the entire building. During Phase 3, TCC developed a close partnership with SCE, leading to additional Build-to-Suit opportunities at Innovation Village. In 2009 and again in 2014, TCC was selected as the Developer to design, entitle, and construct Phase 4 and Phase 5 as additional state-of-the-art office buildings to house SCE's Transmission Business Unit.

ARENA CORPORATE CENTER - ANAHEIM, CA



PROJECT:	**ARENA CORPORATE CENTER**
LOCATION:	Anaheim, CA
COMPLETION DATE:	2003, On Time and Under Budget
PROJECT TYPE:	Speculative Class A Office Park
SQUARE FOOTAGE:	385,000 SF
PROJECT SUMMARY:	Arena Corporate Center is a prime example of how TCC's capabilities benefit our clients. Trammell Crow Company purchased 23 acres of land directly adjacent to the Arrowhead Pond in August 2001. The project, comprised of 3 two-story buildings totaling 385,000 square feet, was considered risky by industry experts due to rising vacancy rates, falling rental rates and the languishing recession.

The TCC team recognized that the submarket lacked quality back office space and determined the local tenant base would prefer a campus type environment, a product that was lacking in Central Orange County. Based on these findings, our team scrapped the existing entitled plans and designed 3 two-story buildings with the largest floor plates in the market. The project includes a one-acre palm tree courtyard with electrical and data hookups, outdoor jogging tracks, basketball court and on site showers. Tenants benefit from features such as 1,000 feet of visibility from the 57 freeway, traffic of almost 300,000 cars per day and 5:1 parking.

The project was an immediate success with Tenant Healthcare signing the first lease for 150,000 square feet prior to groundbreaking in March 2002. Construction was completed in June of 2003 and the project was 100% leased at above pro forma rents just 4 months later. Tenants include: Washington Mutual (56,210 SF), Advantage Sales (46,432 SF), Ameriquest (127,750 SF).

THE BOARDWALK - IRVINE, CA



PROJECT:	**THE BOARDWALK**
LOCATION:	Irvine, CA
COMPLETION DATE:	Projected Completion Summer 2017, Currently On Time & On Budget
PROJECT TYPE:	Class A Speculative Office Campus
SQUARE FOOTAGE:	545,385 SF
PROJECT SUMMARY:	Located on Orange County's most traveled thoroughfare, this 7.5 acre project will be comprised of two, nine-story towers totaling approximately 545,000 square feet of best-in-class office space, two acres of landscaped outdoor space, and abundant on-site amenities. Designed by world renowned architect Gensler, The Boardwalk is poised to revolutionize the Orange County workplace through a perfect blend of form and function, delivering not only iconic architecture and a picturesque landscape, but a design that promotes productivity, efficiency, wellness, and a coastal lifestyle. The buildings offer large floor plates, connected on alternating floors with indoor bridges and outdoor terraces. By bridging the two buildings, The Boardwalk provides the opportunity for up to 65,000 square feet of contiguous space on a single floor, offering unmatched connectivity and efficiency, and office and amenity space unlike anything else in the market. This cutting edge design will enhance productivity by promoting collaboration and demonstrate a creative culture. The Boardwalk offers a comprehensive amenity package including indoor and outdoor workspace, on-site fitness and wellness center, and on-site dining options to provide a well-rounded lifestyle for its occupants. The project is currently under construction, with completion scheduled for Summer of 2017. Leasing is underway, with multiple leases and LOI's currently being negotiated with potential to account for over 400,000 SF of space.

RIVERSIDE UNIVERSITY HEALTH SYSTEM MOB - MORENO VALLEY, CA



PROJECT: **RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL OFFICE BUILDING**

LOCATION: Moreno Valley, CA

COMPLETION DATE: Projected Completion 4Q 2019

PROJECT TYPE: Master Planned Development, Phase 1: Class A Build-to Suit Medical Office Building

SQUARE FOOTAGE: 200,000 SF

PROJECT SUMMARY: In April 2015, Trammell Crow Company's Southern California Business Unit was selected as the Master Developer and Owner to plan, design, entitle and construct a state of the art medical office building for the County of Riverside Economic Development Agency and the Riverside University Health System Medical Center. The new building would be located within the existing parking field of the Medical Center and would provide ambulatory care services and ancillary functions for the hospital.

TCC was requested to provide a 200,000 SF MOB located directly in front of the main entrance to the hospital from Cactus Avenue. The building was sited in a manner that allows for connectivity to the existing Education Building & parking fields, as well as future integration into the hospital campus and a proposed parking structure to the east. The location of the building required the re-location of the main entry drive further from the current southern location to the west and creating a new 8,000 SF Lobby/Café building with a connected canopy structure to bring visitors and patients in from the west side of the hospital. Services provided include multi-specialty clinics, outpatient surgery, and physical therapy programs.

After evaluating various financing structures, it was determined that the MOB would be constructed with funds secured through a Credit Tenant Lease (CTL). CTL loans are credit-based debt instruments that provide fully amortizing loans that are coterminous with a tenant's lease. This unique and extremely complex financing vehicle provides tenants with investment grade credit, the ability to finance the entire cost of a new facility through a "rent-to-own" structure. CTL financing offers options for both monetizing existing assets and capitalizing build to suits.

In April 2017, TCC successfully completed entitlements, finalized negotiations on the ground lease and facilities lease, and secured the CTL loan for the County of Riverside. Construction of the 200,000 SF MOB facility is slated to commence later this year, with completion projected for 4Q 2019.

SECTION 2. ADDITIONAL QUESTIONS

A. PROVIDE ANY COMMENTS, OBSERVATIONS OR SUGGESTIONS WHICH MAY ASSIST CALOPTIMA IN DRAFTING A PROCUREMENT SOLICITATION.

TCC has vast experience working with numerous public agencies throughout the RFP and ultimately the development process. As a result, some of the fundamental elements that we have identified and recommend which will allow for the smoothest and most efficient procurement process include:

1. Provide a central point of contact for the decision making team. A clear line of communication will simplify and expedite the procurement and negotiation process.

2. Be prepared with a streamlined decision making process. As outlined below, the entire development process will take two or more years to complete. In order to capitalize on the in-place entitlements and current market demand, CalOptima and the new buyer will need to ready to move quickly and efficiently.

3. If possible, be prepared to further define CalOptima's future space requirements prior to issuance of the RFP. Quantifying the square footage required reduces risk by providing greater certainty for the developer and could expedite the overall development process.

4. Evaluate the overall quality of the developer as part of the offer. In addition to the basic terms of the proposal, CalOptima's consideration should include not only track record, experience, and capitalization, but also the reputation and culture. At a minimum, CalOptima will be neighboring the new building, and could potentially occupy space in the new project. As such, a collaborative buyer and potential partner will be a critical element in the next phase of the project.

B. PLEASE PROVIDE A BRIEF SUMMARY OF HOW YOU MIGHT ENVISION THE TRANSACTION STRUCTURES THAT YOUR FIRM WOULD PROPOSE.

As outlined in the above case studies, TCC has the capability to finance and develop premier office space under various deal structures and can offer a range of financing structures. Our team is equally well suited for traditional joint venture relationships with institutional capital partners, as well as collaborative partnerships with governmental and public agencies. We have substantial experience with and are open to various deal structures. While each arrangement is ultimately market driven, we focus on how we can assist and deliver results to our clients.

1. **Direct Fee Purchase: CalOptima may consider a direct fee purchase of the Excess Land and associated entitlements. Respondent's proposal for this approach must include estimates of proposed purchase price, transaction timing, and other general provisions of Respondent's proposal.**

   While TCC anticipates fair market value for the land and associated entitlements, additional aspects of the project would need to be further understood before pricing could be determined. TCC is highly interested and prepared to pursue this asset, but will require additional information relating to status of entitlements, CC&R's, off-sites, subdivision process, reciprocal parking agreements, exactions, and plan check and permit fees. Additionally, CalOptima's future requirements for space or options on space could have an impact on what would be determined to be fair market value.

2. **Ground Lease/Participating Ground Lease: CalOptima may consider a ground lease of the Excess Land. In the case of a ground lease, or participating ground lease proposal, the Offeror should include an estimated initial base rent, lease term and lease payment commencement, proposed escalation, ground lease term, subordination (an unsubordinated ground lease is strongly preferred), and other general terms of the ground lease/participating ground lease. In the event Offeror proposes a participating ground lease, Offeror's proposal should include minimum rent, percentage participating, formula and basis for participation as well as the other terms addressed in the fixed ground lease proposal.**

   While Trammell Crow Company's Newport Beach Business Unit has extensive experience with ground leases, it is not our preferred deal structure. However, we have a thorough understanding of the process, including the unique nuances of underwriting and structuring of ground lease documents. In the eyes of the ownership and investment community, the ground lease is generally considered to be an inferior structure to fee simple ownership. As such, the terms of the ground lease would need to reflect this discount in valuation.

Under a ground lease scenario, the rent or rate of return to CalOptima as the ground lessor will be largely dependent upon the requirement as a tenant. In order to appropriately propose pricing, TCC will need to further understand whether the existing building would be included, and if so, the physical condition and CalOptima's intended occupancy duration of the existing building, as well as any potential future space and timing needs within the new building.

3. **Joint Venture: While a joint venture between a private-sector entity and a public agency does present its challenges, CalOptima wants to remain flexible with regard to potential transaction structures that may enhance cash flow, flexibility and overall economic benefit for the agency. Respondents proposing a joint venture structure should address joint venture structure preferential rates of return, capital contribution values, distribution priorities and capital risk exposure. Please keep in mind that CalOptima will require that its equity value be in first priority and not subject to foreclosure risk.**

   TCC has completed Joint Ventures in various forms with public and governmental agencies, as well as traditional partnerships with institutional investors. In order to best structure an agreement with any partner, in depth conversations must take place in order to communicate, understand, and agree upon an overall investment strategy. In order to propose the most appropriate deal structure, TCC would request the opportunity to discuss CalOptima's appetite for risk, return expectations, equity and debt contributions, investment duration, and potential occupancy needs within the to-be-built building.

   By determining CalOptima's future needs, TCC can establish a clear and strategic go forward strategy that will maximize the value of the property, as well as provide or arrange for a variety of financing vehicles which will provide ultimate flexibility for both parties.

4. **Potential Trade: As part of its mandated healthcare delivery mission for the residents of Orange County, CalOptima anticipates that its staffing levels may continue to increase over the coming years. While CalOptima does not occupy all of the current building, it anticipates that as a space in the building is recaptured, its space needs may exceed the capacity of the current building. As such, acquisition of a nearby, preferably, adjacent building may be of interest to CalOptima. Respondents that currently own a nearby building may want to consider proposing a trade of the Excess Land for such a building. Respondents considering this approach should address: the location and physical condition of the trade property, any existing leases or other restrictions on occupancy, building condition, and terms of trade.**

   TCC is open to exploring trade opportunities following further discussion and understanding of CalOptima's needs and requirements.

C. If possible, please provide preliminary economic results of how you might see a transaction being structured.

As previously discussed, TCC is open to and will entertain various types of structures. However, returns will be predicated upon market forces, as well as a number of economic factors which will need to be further discussed as a partnership or buyer/seller relationship progresses. As a potential occupant of the to-be-built building, the needs of CalOptima will be a primary driver in how best to structure a deal and potential profitability. TCC brings substantial experience and expertise in the development process, as well as deal structure creativity and capital relationships which provide for ultimate flexibility in delivering a variety of finance vehicles, including traditional equity and debt joint ventures, tax exempt bond financing, Credit Tenant Leases (CTL), or synthetic leases, among others. TCC will be better suited to address profitability for both parties after assessing CalOptima's needs as both a tenant and investor.

D. Please provide a potential timeline for any of the structures that you believe might be appropriate for your firm.

Following the April 21st receipt of the RFI responses CalOptima will need to read, evaluate, and interview the respondents. By allowing 30 to 45 days for that process, TCC would estimate a June 2017 commencement and the following approximate timelines if an RFP was deemed necessary.

a) RFP – 60 to 90 days
b) PSA / JV document – 30 days
c) Escrow – 60 to 90 days
d) Design – 10 to 12 months
e) Construction – 14 to 18 months
f) Lease Up of non-CalOptima space – TBD subject to determining CalOptima expansion requirement – 0 to 24 months

E. Please outline the obligations that your firm would request of CalOptima as part of any transaction structure.

As a potential partner or purchaser of the property, TCC would request from CalOptima, the following obligation and information:

- Exclusive right to negotiate
- Further understanding of CalOptima's timing expectations for identifying future expansion needs
- Further understanding of CalOptima's preferred deal structure
- Further understanding of CalOptima's experience and history as both a Joint Venture Partner or Ground Lessor

TESTIMONIALS

Trammell Crow Company

amazon

"Trammell Crow Company's teamwork atmosphere and leadership in the development process has led to a highly successful project for all parties concerned."

"Trammell Crow Company is a great partner, and we look forward to continuing our relationship."

"Their expertise in development management and their knowledge of the university's and the state's approval process greatly aided the project team in successfully completing these two projects in a timely manner; allowing SCE to move personnel into the facilities ahead of all expectations. Their guidance and counsel to the project team was invaluable. All personnel associated with the project were both helpful and professional in all aspects."

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City of Alhambra

"Trammell Crow Company team leadership capabilities and knowledge of development has created an effective relationship with City Staff and a proactive approach to the development which has yielded an outstanding project that will enhance the City Central Business District for years to come. Trammell Crow Company continues to be a reliable partner, one that meets their obligations and commitments to the community."

"The Cal Poly Pomona Foundation highly recommends the Trammell Crow Company as a developer. We are very pleased to be partnering with them now, and we look forward to future partnerships."

Cal Poly Pomona Foundation

COUNTY OF LOS ANGELES CALIFORNIA

"The Community Development Commission of the County of Los Angeles wishes to express its appreciation to the Trammell Crow Company... "

"Trammell Crow Company's excellence as a developer is second to none. The firm meets its commitments."

Trammell Crow Company

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Newport Beach, CA 92660
(949) 477-4700

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State of California

WELFARE AND INSTITUTIONS CODE

Section 14087.54

14087.54. (a) Any county or counties may establish a special commission in order to meet the problems of the delivery of publicly assisted medical care in the county or counties and to demonstrate ways of promoting quality care and cost efficiency.

(b) (1) A county board of supervisors may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter. The boards of supervisors of more than one county may also establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. If a board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to "county" shall mean a commission established pursuant to this section.

(2) A commission operating pursuant to this section may also enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits under any publicly supported program, if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs. The commission shall not use any payments or reserves from the Medi-Cal program for this purpose.

(3) In addition to the authority specified in paragraph (1), the board of supervisors may, by ordinance, authorize the commission established pursuant to this section to provide health care delivery systems for any or all of the following persons:

(A) Persons who are eligible to receive medical benefits under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395).

(C) Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The commission shall not use any payment or reserve from the Medi-Cal program for purposes of this subparagraph.

(4) Nothing in this section shall prohibit a commission established pursuant to this section from providing services pursuant to subparagraph (C) of paragraph (3) in counties other than the commission's county if the commission is approved by the Department of Managed Health Care to provide services in those counties. The

commission shall not use any payment or reserve from the Medi-Cal program for purposes of this paragraph.

(5) For purposes of providing services to persons described in subparagraph (A) or (B) of paragraph (3), if the commission seeks a contract with the federal Centers for Medicare and Medicaid Services to provide Medicare services as a Medicare Advantage program, the commission shall first obtain a license under the Knox-Keene Health Care Service Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(6) With respect to the provision of services for persons described in subparagraph (A) or (B) of paragraph (3), the commission shall conform to applicable state licensing and freedom of choice requirements as directed by the federal Centers for Medicare and Medicaid Services.

(7) Any material, provided to a person described in subparagraph (A) or (B) of paragraph (3) who is dually eligible to receive medical benefits under both the Medi-Cal program and the Medicare Program, regarding the enrollment or availability of enrollment in Medicare services established by the commission shall include notice of all of the following information in the following format:

(A) Medi-Cal eligibility will not be lost or otherwise affected if the person does not enroll in the plan for Medicare benefits.

(B) The person is not required to enroll in the Medicare plan to be eligible for Medicare benefits.

(C) The person may have other choices for Medicare coverage and for further assistance may contact the federal Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or www.Medicare.gov.

(D) The notice shall be in plain language, prominently displayed, and translated into any language other than English that the commission is required to use in communicating with Medi-Cal beneficiaries.

(c) It is the intent of the Legislature that if a county forms a commission pursuant to this section, the county shall, with respect to its medical facilities and programs occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as a board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered an entity separate from the county or counties, shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and shall file the statement required by Section 53051 of the Government Code. The commission shall have in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section

6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(e) Upon creation, a commission may borrow from the county or counties, and the county or counties may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event a commission may no longer function for the purposes for which it was established, at the time that the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board or boards of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of a commission, the board or boards of supervisors shall notify the State Department of Health Care Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board or boards within 10 days of completion of the audit. The board or boards shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of a commission by the board or boards, the county or counties shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county or counties upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of a commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

(j) Nothing in this section shall be construed to supersede Section 14093.06 or 14094.3.

(Amended by Stats. 2007, Ch. 483, Sec. 51. Effective January 1, 2008.)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Finance and Audit Committee

Report Item

6. Consider Recommending Board of Directors' Approval of Proposed Revisions to CalOptima's Operations Policies and Procedures

Contact

Belinda Abeyta, Executive Director, Operations (657)-235-6755

Recommended Actions:

Recommend that the Board of Directors:

1. Approve modification of the following policies and procedures in connection with CalOptima's regular review process:
   a. DD.2013: Customer Service Grievance Process
   b. FF.2003: Coordination of Benefits
   c. FF.2005: Conlan, Member Reimbursement
   d. FF.2011: Direct Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services
   e. FF.2012: Direct Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services
   f. MA.3101: Claims Processing

2. Authorize Staff to further update Attachment A of Policies FF.2011 and FF.2012 for the continuation of payment of Directed Payments to eligible non-contracted providers for qualifying non-contracted Ground Emergency Medical Transport (GEMT) services for State Fiscal Year (SFY) 2020-2021 with dates of service between July 1, 2020 and June 30, 2021, upon receipt of and pursuant to DHCS's written instruction to CalOptima prior to the release of DHCS final guidance, with any further changes to Attachment A remaining subject to Board approval.

Background/Discussion

CalOptima staff regularly reviews the organization's Policies and Procedures to ensure that they are up-to-date and aligned with Federal and State health care program requirements, contracts obligations, and laws, as well as CalOptima operations.

Modification to CalOptima Policies. Proposed policy modifications are summarized below:

1. ***DD.2013: Customer Service Grievance Process*** defines the criteria by which a CalOptima's Customer Service department intakes, addresses, resolves, and tracks grievances from a member, a member's authorized representative or a provider acting on behalf of a member, in accordance with applicable statutory, regulatory, and contractual requirements. CalOptima staff recommends revising the policy to ensure its alignment with current operational processes and regulatory requirements.

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Proposed revisions include distinguishing a "grievance" from an "inquiry" and modifications of definitions.

2. ***FF.2003: Coordination of Benefits*** defines the criteria by which CalOptima's Claims Administration Department determines Coordination of Benefits (COB), or order of payment, for payment of covered services when a member has active coverage by more than one group health plan. CalOptima staff proposes revising this policy pursuant to the CalOptima annual review process to ensure alignment with current operational systems and regulatory requirements of the Department of Health Care Services (DHCS) *All Plan Letter (APL) 20-010: Cost Avoidance and Post-Payment Recovery for Other Health Coverage*. Recommended revisions include ensuring with current operational processes and regulatory requirements, including revision of definitions and adding procedural changes consistent with *DHCS All Plan Letter (APL) 20-010: Cost Avoidance and Post-Payment Recovery for Other Health Coverage*.

3. ***FF.2005: Conlan, Member Reimbursement*** defines the criteria by which CalOptima's Claims Administration Department complies with DHCS *Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process*, the court-ordered reimbursement process to members for paid out-of-pocket expenses for Medi-Cal covered services. CalOptima staff recommends revising the policy to ensure its alignment with current operational processes and regulatory requirements. Proposed revisions include modifications to definitions and removing references to CalOptima Policy *GG.1413: Polypharmacy Management* and CalOptima Policy *GG.1416: Pharmacy Home Program* as these policies are no longer applicable to policy *FF.2005: Conlan, Member Reimbursement* with DHCS transition of pharmacy benefits for Medi-Cal members to Medi-Cal Rx carve-out effective January 1, 2021.

4. ***FF.2011: Direct Payments for Qualifying Services Rendered to CalOptima Health Network Member When Health Networks are Financially Responsible for the Qualifying Services*** defines the criteria by which Health Networks comply with the DHCS Direct Payment program guidance. CalOptima staff recommends revising the policy to ensure alignment with current operational processes and regulatory requirements. Proposed revisions include modifications to definitions, the addition of regulatory requirements as stated in DHCS *All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services*, and DHCS *All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments* updates to Attachment A: Direct Payments Rates and Codes to include Proposition 56: Family Planning Services and Proposition 56: Valued-Based Payment (VBP) Program Services, and the addition of new Attachment B: VBP Program Specifications: Value-Based Payment Program Performance Measures 2020.

5. ***FF.2012: Direct Payments for Qualifying Services Rendered to CalOptima Direct or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services*** defines the criteria by which CalOptima will comply with the DHCS Direct Payment program guidance. CalOptima staff recommends revising the policy to ensure alignment with current operational processes and regulatory requirements. Proposed revisions include modifications to definitions, addition of regulatory requirements as stated in DHCS *All Plan*

Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services, and DHCS *All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments* updates to Attachment A: Direct Payments Rates and Codes to include Proposition 56: Family Planning Services and Proposition 56: Valued-Based Payment (VBP) Program Services, and the addition of new Attachment B: VBP Program Specifications: Value-Based Payment Program Performance Measures 2020.

6. ***MA.3101: Claims Processing*** defines the criteria by which CalOptima's Claims Administration Department ensures the timely and accurate processing and adjudication of claims by CalOptima or a health network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR). CalOptima staff recommends revising the policy to ensure its alignment with current operational processes and regulatory requirements. Proposed revisions include notifications to definitions and adding requirements for reopening and revision of claim determinations as required under *Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revisions of Claim Determinations and Decisions*.

Directed Payments for GEMT Services (SFY 2020-2021). CalOptima Policies FF.2011 and FF.2012 include directed payments to eligible non-contracted providers for qualifying non-contracted Ground Emergency Medical Transport (GEMT) services for State Fiscal Years (SFYs) 2018-19 and 2019-20. On October 15, 2020, the Centers for Medicare & Medicaid Services (CMS) approved the State Plan Amendment (SPA) 20-0009 for the continuation of directed payments for GEMT services for SFY 2020-21 with dates of service between July 1, 2020 and June 30, 2021. The approved SPA includes directed payment rates and codes that are the same as the preceding SFY 2019-2020. However, DHCS has not yet released the final All Plan Letter for SFY 2020-21, which, based on prior experience, could take approximately four months from the date of the approved SPA. Staff is seeking written instruction from DHCS on whether to continue to pay the directed payments for such GEMT services prior to the release of the final APL and, therefore, is requesting the Board for authority to update Attachment A: Directed Payments Rates and Codes (Attachment A) of CalOptima Policies FF.2011 and FF.2012 upon receipt of and pursuant to DHCS written instruction.

Staff's request for authority, as described above, is limited and does not extend to directed payments for GEMT services for subsequent SFYs or any other Directed Payment programs.
Any further changes to Attachment A of Policy FF.2012 are subject to Board approval. While the Board previously authorized the Chief Executive Officer to update and amend Attachment A of Policy FF.2011 pursuant to DHCS final guidance or written instruction to CalOptima, in order to align with the approach for Policy FF.2012, staff proposes that any further changes to Attachment A of Policy FF.2011 will also be subject to Board approval.

Fiscal Impact

The recommended action to revise CalOptima Policies DD.2013, FF.2003, FF.2005 and MA.3101 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

The recommended action to revise Attachment A: Directed Payments Rates and Codes of CalOptima Policies FF.2011 and FF.2012 is projected to be budget neutral to CalOptima. Staff anticipates funding

provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima. All other revisions to CalOptima Policies FF.2011 and FF.2012 are operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rational for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable requirements, staff recommends that the Board approve and adopt the proposed updates to the presented CalOptima policies and procedures. The updated policies and procedures will supersede the prior versions.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DD.2013: Customer Service Grievance Process
2. FF.2003: Coordination of Benefits
3. FF.2005: Conlan, Member Reimbursement
4. FF.2011: Direct Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services
5. FF.2012: Direct Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services
6. MA.3101: Claims Processing
7. DHCS All Plan Letter (APL) 20-010: Cost Avoidance and Post-Payment Recovery for Other Health Coverage
8. DHCS All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement
9. DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
10. DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments
11. DHCS California State Plan Amendment (SPA) CA-20-0009
12. Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Direct Payments Policy
13. Board Action dated June 4, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy and Modifications to Claims Administration Policies and Procedures

/s/ Richard Sanchez *11/10/2020*
Authorized Signature **Date**

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Policy:	DD.2013
Title:	~~Exempt~~Customer Service Grievance Process
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	12/01/2016
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 2020 1119 HAC Review Only

I. PURPOSE

This policy outlines the process by which the CalOptima Customer Service Department intakes, addresses, resolves, and tracks ~~an Exempt Grievance~~Grievances from a Member, ~~or~~ a Member's Authorized Representative, or a Provider acting on behalf of a Member, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima and its contracted Health Networks shall establish and maintain a Grievance process to intake, triage, and address a Member's, a Member's Authorized Representative, or Provider acting on behalf of the Member, expression of dissatisfaction and/or a request to file a Grievance for review and Resolution.

B. CalOptima and its contracted Health Networks Grievance process shall distinguish an "Inquiry," which is a request for information that does not include an expression of dissatisfaction, from a Grievance which is a written or oral expression of dissatisfaction about any matter other than an Adverse Benefit Determination pursuant to Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

~~A.~~C. Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day~~,~~ are exempt from the requirement from sending a written acknowledgment and response and shall be classified as an Exempt Grievance.

~~B. CalOptima shall establish and maintain an Exempt Grievance process by which a Member, or a Member's Authorized Representative, or a provider acting on behalf of a Member, may express discontent or dissatisfaction for resolution.~~

~~C. CalOptima's Exempt Grievance process shall address the MemberMember's Authorized Representative's, or a provider's, acting on behalf of a Member, dissatisfaction or discontent in accordance with applicable statutory, regulatory, and contractual requirements.~~

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D. CalOptima and its contracted Health Networks shall refer all potential medical quality of care issues identified through the ~~Exempt~~Customer Service Grievance process to the CalOptima Grievance and Appeals Resolution Service (GARS) Department for action. GARS' actions may include, ~~including~~ but are not limited to, referral to the CalOptima Quality Improvement Department for review, in accordance with CalOptima Policy HH.1102: Member Grievance.

E. CalOptima and its contracted Health Networks shall inform a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, of ~~their~~the right to file a Grievance through CalOptima at ~~anytime~~any time, in accordance with Title 42 of the Code of Federal Regulations, Section 438.402(c)(2)(i).

F. ~~CalOptima shall maintain written records and log of each~~CalOptima and its contracted Health Networks shall not discourage the filing of Grievances. A Member, Member's Authorized Representative, or a Provider acting on behalf of a Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance.

~~F.~~G. CalOptima and its contracted Health Networks shall maintain records and logs of each standard and Exempt Grievance, including the date of receipt, name of complainant, Member's name and client identification number (CIN), nature of the ~~Exempt~~ Grievance, names of the CalOptima staff who received the ~~Exempt~~ Grievance, and name of the CalOptima staff who resolved the ~~Exempt~~ Grievance and ensure ~~Exempt~~ Grievances are included in the aggregated Grievance data reported to the Department of Health Care Services (DHCS).

~~G.~~H. CalOptima and its contracted Health Networks shall ensure that there is no discrimination against a Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member on the grounds that the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member filed ~~an Exempt~~a Grievance~~, in accordance with Section III.C. of this policy~~.

III. PROCEDURE

~~A. Exempt Grievance Process~~

A. Inquiry

1. If a ~~A~~ Member, a Member's Authorized Representative, or a ~~provider~~Provider acting on behalf of a Member, contacts the Customer Service Department, by telephone or in-person, and ~~may express~~an requests information pertaining to eligibility, benefits, or other CalOptima processes with no expression of dissatisfaction, it is an Inquiry, rather than a Grievance.~~, or discontent, to CalOptima's~~the ~~Customer Service Department by telephone, or in person.~~

2. CalOptima's Customer Service staff shall:

a. Identify and document the ~~cause~~nature of the ~~Member, Member's Authorized Representative's, or provider's, acting on behalf of a Member, dissatisfaction; Educate~~Inquiry given by the Member, Member's Authorized Representative, or ~~a provider~~Provider acting on behalf of a Member;

b. Categorize the Inquiry with the appropriate subject and category codes;

c. Provide the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member~~, on their right~~ with the requested information; and

For 20201119 FAC Review Only

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d. Close the Inquiry with the appropriate disposition codes.

B. Standard Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, can request to file a grievance to the Customer Service Department by telephone, or in person.

2. CalOptima's Customer Service staff shall:

a. Identify and document the nature of the Grievance given by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Inform the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member of the Resolution timeframes;

c. Mark the grievance with the appropriate Priority Code (routine or urgent); and

~~a.~~d. Route the Grievance to the GARS Department. The GARS Department shall process the Grievance in accordance with CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint;~~Grievance.

3. ~~Determine if they are able to provide a resolution to the Member's~~The Customer Service Department shall continue to assist the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member with any additional or immediate needs.

C. Exempt Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, may express dissatisfaction, or discontent, to CalOptima's Customer Service Department by telephone, or in person.

2. The Customer Service Department staff shall:

a. Identify and document the nature of the dissatisfaction ~~or discontent by~~expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Document all actions taken to address the dissatisfaction expressed by the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member, as well as the Resolution provided in response to the dissatisfaction expressed by the Member~~'s~~, Member's Authorized Representative, or Provider acting on behalf of the Member; and

~~a.~~c. If the Grievance is resolved by the close of the ~~following~~next business day~~;~~, close the Grievance with the appropriate disposition codes.

~~2.~~3. ~~Clearly document~~If Customer Service Department staff is unable to provide Resolution to the Member, a Member's Authorized Representative, or ~~a provider's,~~Provider acting on behalf of a Member, dissatisfaction or discontent~~, as well as the resolution provided in response to the Member's, Authorized Representative's, or provider's contact;~~ by close of the next business day, CalOptima's Customer Service staff shall:

a. ~~Flag~~Educate the Member, a Member's Authorized Representative, or a ~~provider's~~Provider acting on behalf of a Member, ~~dissatisfaction for reporting purposes; Provide language~~

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~~assistance for Threshold Languages and language line interpretation services, as needed, to register and resolve the Exempt~~ of Grievance~~; and Make one (1) attempt to call the~~ rights, in accordance with CalOptima Policy HH.1102: CalOptima Member ~~back if the call is disconnected while~~Complaint, and inform the issue(s) will be referred to the GARS Department;

b. Inform the Member, a Member's Authorized Representative, or a ~~provider~~Provider acting on behalf of a Member ~~expresses dissatisfaction during~~of the Resolution timeframes; and

~~a.~~c. If the ~~call~~Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member agrees to refer the Grievance, route grievance to the GARS Department.

4. If the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member expressly declines to file the Grievance, Customer Service staff shall:

a. Categorize the issue as a Grievance;

b. Continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member until the Grievance is fully resolved; and

c. Close the Grievance with the "Declined Grievance/Resolved" disposition code.

~~B.~~D. Records and Reports

1. ~~CalOptima's~~The Customer Service Department staff shall log the call into the core business system to document receipt of the ~~Exempt~~ Grievance, the disposition and ~~the resolution~~Resolution provided to the Member, Member's Authorized Representative, or a ~~provider~~Provider acting on behalf of a Member.

2. ~~CalOptima's~~The Customer Service Department shall maintain a ~~report of~~record in the core business system for each standard and Exempt Grievance, including the date of receipt, Member's name and client identification number (CIN), nature of the ~~Exempt~~ Grievance, the ~~resolution~~Resolution provided, and the Customer Service Representative's name who took the call and resolved the Exempt Grievance.

3. ~~CalOptima's~~The Customer Service Department shall ~~maintain a report of each Exempt~~, on a monthly basis, provide a "Declined Grievance ~~flagged as a quality of care concern, which is~~/Resolved" report to GARS to be ~~forwarded to the CalOptima Quality Improvement Department~~ aggregated for ~~further investigation upon completion of the call, or visit. Customer Service Department Managers~~tracking and ~~Directors~~trending purposes as with other Grievances.

~~3.~~4. The Customer Service and GARS Department management staff shall, on a monthly ~~and quarterly~~ basis, review reports for tracking and trending of ~~Exempts~~Exempt Grievances by Provider, Health Network, and Grievance category.

~~4.~~5. The Customer Service Department shall ensure Exempt Grievances are incorporated in the quarterly Grievance and Appeals Report.

~~C. CalOptima and its contracted Health Networks shall not discriminate or retaliate against any Member on grounds that such Member filed an Exempt Grievance, in accordance with CalOptima Policy HH.3012A: Non-Retaliation for Reporting Violations.~~

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance
D. CalOptima Policy HH.1103: ~~CalOptima~~ Health Network Member ~~Complaint~~Grievance and Appeal Process
~~E. CalOptima Policy HH.3012A: Non-Retaliation for Reporting Violations~~
~~F.~~E. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~G. Health and Safety Code, §1368(a)(4)(B)~~
~~H.~~F. Title ~~28, California~~42 Code of Federal Regulations (C.~~CF~~.R~~), §1300.68(d)(8) .~~), § 438.402(c)(2)(i)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
06/21/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	06/01/2017	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	10/01/2018	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	TBD	DD.2013	Customer Service Grievance Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors ~~and as further described in CalOptima Policy HH.3009.~~
Complaint	A complaint is the same as a Grievance. Where the Customer Service staff is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.
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.
Exempt Grievance	Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response.
Grievance	~~An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.~~ A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's 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.
~~Inquiry~~	A request for information that does not include an expression of dissatisfaction. Inquiries may include, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima processes.
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.

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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.
Resolution	~~The state at which a grievance or exempt~~The grievance has reached a final conclusion with respect to the ~~Member or Provider's~~ submitted ~~grievance~~Grievance.
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.2013
Title:	**Customer Service Grievance Process**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	12/01/2016
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20201119 HAC Review Only

I. PURPOSE

This policy outlines the process by which the CalOptima Customer Service Department intakes, addresses, resolves, and tracks Grievances from a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima and its contracted Health Networks shall establish and maintain a Grievance process to intake, triage, and address a Member's, a Member's Authorized Representative, or Provider acting on behalf of the Member, expression of dissatisfaction and/or a request to file a Grievance for review and Resolution.

B. CalOptima and its contracted Health Networks Grievance process shall distinguish an "Inquiry," which is a request for information that does not include an expression of dissatisfaction, from a Grievance which is a written or oral expression of dissatisfaction about any matter other than an Adverse Benefit Determination pursuant to Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

C. Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day are exempt from the requirement from sending a written acknowledgment and response and shall be classified as an Exempt Grievance.

D. CalOptima and its contracted Health Networks shall refer all potential medical quality of care issues identified through the Customer Service Grievance process to the CalOptima Grievance and Appeals Resolution Service (GARS) Department for action. GARS' actions may include, but are not limited to, referral to the CalOptima Quality Improvement Department for review, in accordance with CalOptima Policy HH.1102: Member Grievance.

E. CalOptima and its contracted Health Networks shall inform a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, of the right to file a Grievance through

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CalOptima at any time, in accordance with Title 42 of the Code of Federal Regulations, Section 438.402(c)(2)(i).

F. CalOptima and its contracted Health Networks shall not discourage the filing of Grievances. A Member, Member's Authorized Representative, or a Provider acting on behalf of a Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance.

G. CalOptima and its contracted Health Networks shall maintain records and logs of each standard and Exempt Grievance, including the date of receipt, name of complainant, Member's name and client identification number (CIN), nature of the Grievance, names of the CalOptima staff who received the Grievance, and name of the CalOptima staff who resolved the Grievance and ensure Grievances are included in the aggregated Grievance data reported to the Department of Health Care Services (DHCS).

H. CalOptima and its contracted Health Networks shall ensure that there is no discrimination against a Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member on the grounds that the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member filed a Grievance.

III. PROCEDURE

A. Inquiry

1. If a Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, contacts the Customer Service Department, by telephone or in-person, and requests information pertaining to eligibility, benefits, or other CalOptima processes with no expression of dissatisfaction, it is an Inquiry, rather than a Grievance.

2. CalOptima's Customer Service staff shall:

   a. Identify and document the nature of the Inquiry given by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

   b. Categorize the Inquiry with the appropriate subject and category codes;

   c. Provide the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member with the requested information; and

   d. Close the Inquiry with the appropriate disposition codes.

B. Standard Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, can request to file a grievance to the Customer Service Department by telephone, or in person.

2. CalOptima's Customer Service staff shall:

   a. Identify and document the nature of the Grievance given by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

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b. Inform the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member of the Resolution timeframes;

c. Mark the grievance with the appropriate Priority Code (routine or urgent); and

d. Route the Grievance to the GARS Department. The GARS Department shall process the Grievance in accordance with CalOptima Policy HH.1102: Member Grievance.

3. The Customer Service Department shall continue to assist the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member with any additional or immediate needs.

C. Exempt Grievance

1. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, may express dissatisfaction, or discontent, to CalOptima's Customer Service Department by telephone, or in person.

2. The Customer Service Department staff shall:

a. Identify and document the nature of the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

b. Document all actions taken to address the dissatisfaction expressed by the Member, Member's Authorized Representative, or a Provider, acting on behalf of a Member, as well as the Resolution provided in response to the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of the Member; and

c. If the Grievance is resolved by the close of the next business day, close the Grievance with the appropriate disposition codes.

3. If Customer Service Department staff is unable to provide Resolution to the Member, a Member's Authorized Representative, or Provider acting on behalf of a Member, dissatisfaction or discontent by close of the next business day, CalOptima's Customer Service staff shall:

a. Educate the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, of Grievance rights, in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint, and inform the issue(s) will be referred to the GARS Department;

b. Inform the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member of the Resolution timeframes; and

c. If the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member agrees to refer the Grievance, route grievance to the GARS Department.

4. If the Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member expressly declines to file the Grievance, Customer Service staff shall:

a. Categorize the issue as a Grievance;

b. Continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member until the Grievance is fully resolved; and

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c. Close the Grievance with the "Declined Grievance/Resolved" disposition code.

D. Records and Reports

1. The Customer Service Department staff shall log the call into the core business system to document receipt of the Grievance, the disposition and Resolution provided to the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member.

2. The Customer Service Department shall maintain a record in the core business system for each standard and Exempt Grievance, including the date of receipt, Member's name and client identification number (CIN), nature of the Grievance, the Resolution provided, and the Customer Service Representative's name who took the call and resolved the Exempt Grievance.

3. The Customer Service Department shall, on a monthly basis, provide a "Declined Grievance/Resolved" report to GARS to be aggregated for tracking and trending purposes as with other Grievances.

4. The Customer Service and GARS Department management staff shall, on a monthly basis, review reports for tracking and trending of Exempt Grievances by Provider, Health Network, and Grievance category.

5. The Customer Service Department shall ensure Exempt Grievances are incorporated in the quarterly Grievance and Appeals Report.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy HH.1102: Member Grievance
D. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
F. Title 42 Code of Federal Regulations (C.F.R.), § 438.402(c)(2)(i)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
06/21/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	06/01/2017	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	10/01/2018	DD.2013	Exempt Grievance Process	Medi-Cal
Revised	TBD	DD.2013	Customer Service Grievance Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Complaint	A complaint is the same as a Grievance. Where the Customer Service staff is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.
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.
Exempt Grievance	Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response.
Grievance	A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's 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.
Inquiry	A request for information that does not include an expression of dissatisfaction. Inquiries may include, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima processes.
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.
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.
Resolution	The grievance has reached a final conclusion with respect to the submitted Grievance.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

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Policy:	FF.2003
Title:	**Coordination of Benefits**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy describes the process for determining Coordination of Benefits (COB~~)*,~~), or order of payment, for payment of Covered Services when a Member has active coverage by more than one (1) group health plan.

II. POLICY

A. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan.

B. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort.

C. If a Member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the primary health plan shall pay for the medical, other care, or treatment benefits. CalOptima and a Health Network, as a secondary health plan and payer of last resort, shall adjudicate the claim based on amounts allowed by CalOptima and the primary health plan, whichever is less.

D. If CalOptima identifies OHC unknown to the Department of Health Care Services (DHCS), the Customer Service Department shall report this information to the DHCS Third Party Liability Branch, Other Coverage Unit, within ten (10) calendar days of discovery in an automated format as prescribed by DHCS.

E. An OHC plan, as the primary health plan, shall make payment as appropriate for a Member that has received services that fall within the OHC plan's scope of coverage, or shall deny payment as non-covered benefits, prior to payment consideration by CalOptima or a Health Network.

F. If a Member has both Medicare and an OHC plan, both Medicare and the OHC plan shall pay claims for services prior to payment consideration by CalOptima or a Health Network.

G. CalOptima and a Health Network shall not consider a claim for a Member with a Medicare supplemental policy through an insurance carrier as a Medicare/Medi-Cal Crossover Claim. CalOptima and a Health Network shall consider the Medicare supplemental insurance carrier as the primary health plan and CalOptima and a Health Network as the secondary health plan and the payer of last resort.

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H. CalOptima and a Health Network shall base the COB claim determination period upon the period of time that the Member is actively eligible for Medi-Cal benefits. If there is a break in eligibility and the dates of service falls within the period of time when the Member is not covered by Medi-Cal, CalOptima and the Health Network shall not apply the COB rules to the claim.

I. CalOptima and a Health Network shall make reasonable efforts to recover the value of Covered Services, also referred to as Post-Payment Recovery, or appropriately determine payment of claims for Covered Services, also known as Cost Avoidance, rendered to a Member whenever the Member is fully or partially covered for the same service under any other State or Federal medical care program or under contractual or legal entitlement including, but not limited to, a private group or indemnification program. CalOptima shall rely only on the Medi-Cal ~~Fame~~FAME File eligibility data provided by DHCS and loaded into FACETS™ to recover such payment for OHC.

J. CalOptima and a Health Network may contract with a third-party vendor to recover any payments as described in Section II.I. of this Policy.

K. CalOptima and a Health Network shall have the right to obtain and release COB information and may do so without consent from the Member, or the Member's Authorized Representative. CalOptima and a Health Network shall require a Member to provide insurers with any information needed to make COB determinations, and to pay claims.

L. A Member shall satisfy the monthly Share of Cost (SOC) dollar amount for medical expenses prior to CalOptima certifying the Member to receive Medi-Cal benefits. Upon eligibility certification, the Medi-Cal host computer shall provide an Eligibility Verification Confirmation (EVC) number.

1. CalOptima and a Health Network shall reduce the reimbursement made to a Provider for services rendered to a Member with a SOC by the SOC amount.

2. CalOptima may require a Member with a SOC who has OHC to pay a deductible or a co-payment amount up to his or her SOC. A Provider may bill CalOptima or a Health Network the remaining balance of the deductible or co-payment amount. CalOptima shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less.

3. If a Member has no SOC obligations, a Provider may bill CalOptima or a Health Network for the co-payment or deductible amount. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less (up to the co-pay or deductible amount).

M. A Provider shall not bill or collect deductible or co-payment amounts from a Member, except as provided in Section III.L. of this Policy.

N. Medicare Crossover

1. CalOptima or a Health Network shall pay the annual deductible or co-payment amount for a Member with Medicare Part A, Medicare Part B, or Medicare Part A and Part B, as required by current regulations. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

2. CalOptima or a Health Network shall pay a deductible or co-payment for Medicare Part A acute care inpatient services for a Member, in accordance with current Medi-Cal regulations.

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O. ~~O. On a quarterly basis,~~ CalOptima and a Health Network shall maintain, and on a monthly basis submit, COB reports including, but not limited to reports on Post-Payment Recovery for other health coverage, in accordance with Section III.E. of this Policy and applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance. CalOptima and its Health Networks shall retain ~~COB~~such records for a period of at least ten (10) years after the termination of ~~its~~CalOptima's contract with ~~the~~ DHCS.

III. PROCEDURE

A. CalOptima and a Health Network shall use the following indicators to assess a Member's claim for possible OHC including, but not limited to:

1. Claim forms or Provider billings:
    a. CMS-1500;
    b. UB-04;
    c. PM160 (for dates of service through June 30, 2018 only); or
    d. 25-1.
2. CalOptima or FACETS™:
    a. Health plan carrier codes; or
    b. Medi-Cal eligibility aid codes.
3. Health Network:
    a. Health plan carrier code;
    b. Medi-Cal eligibility aid codes; or
    c. Other insurance information included in the CalOptima Member Eligibility tapes or through the file transfer protocol (FTP) site.
4. Automated Eligibility Verification System (AEVS): As listed on the Supplemental to AEVS Carrier Codes for Other Health Coverage;
5. Photocopies of Remittance Advice Details (RAD);
6. Explanation of Medicare Benefits (EOMB); or
7. Explanation of Payments to Providers (EOP) from other insurance payers.

B. COB Claims Process

1. CalOptima and a Health Network shall review the submitted claim form for indication of OHC. Pursuant to CMS-1500 or UB-04 claim forms, CalOptima and a Health Network shall utilize the following questions to review the claim form including, but not limited to:-

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a. *Does the bill indicate the existence of other insurance coverage*?
Universal claim forms (CMS-1500, UB-04, PM160 (for dates of service through June 30, 2018 only), 25-1) used by physicians, hospitals, and other Providers usually indicate the type of coverage and the insurance carrier, and may provide the group plan name and number. (See Box 11d on CMS-1500 – Is There Another Health Benefit Plan).

b. *Has the bill been paid in part or in whole?*
An attachment to the claim submitted as evidence or explanation of benefits (EOB) may indicate that another plan has already provided benefits. (See Box 29 on CMS-1500 – Amount Paid).

c. *Is the spouse employed?*
If the spouse is employed, the Member may have coverage under the spouse's employer's group health plan. Dependent children may have coverage as dependents under the spouse's coverage. (See Box 9c on CMS-1500 – Employer's Name)

d. *Is the claimant covered by other plans that provide benefits or services?*
Claim forms usually request this information, along with the type of coverage, the name of the insurance carrier, and the group number. (See Box 9a-d on CMS-1500 – Other Insured's Name and Insurance Information)

e. *If the claimant is a child, does the last name differ from that of the insured or covered Member?*
This may indicate coverage through a second parent or a divorce situation in which natural and stepparents cover the child.

f. *Does the claim form indicate that the employee has a former employer?*
This may indicate that the claimant is receiving coverage as a retiree under the former employer's group health plan.

g. *Does the claim form indicate that the claimant is covered under the State or Federal health insurance continuation program?*
This may indicate coverage under a former employer's group health plan (e.g., COBRA).

h. *Is the claimant age sixty-five (65) or older?*
This may indicate the presence of Medicare coverage. (See Box 1 if the Medicare Box is checked and Box 3 on CMS-1500 – Patient's Birth Date)

i. *Is the claimant under age sixty-five (65) and diagnosed with end-stage renal disease (ESRD)?*
This may indicate that the claimant is entitled to Medicare coverage.

j. *If the claim was the result of an accident, where and how did it occur?*
This may indicate that the medical expenses are covered by a Third-Party Liability carrier, such as auto insurance or a homeowner's policy. (See Box 10b on CMS-1500 – Is Patient's Condition Related to Auto Accident or Box 21 on CMS-1500 – Description of Injury)

k. *Were the bills submitted as photocopies?*
This may indicate that the original bills were sent to another health plan carrier for payment.

l. *Were copies of the other carrier's evidence or explanation of benefits or payment submitted instead of the Provider's itemized bill?*
This usually indicates that the claimant has OHC.

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m. *Does the system identify health plan carrier codes as evidence of OHC?*
If available, the Health Network information system should flag the claim for identification of OHC.

2. CalOptima or a Health Network shall not process a COB claim until the primary plan adjudicates the claim or OHC is verified.

3. CalOptima or a Health Network shall process a COB claim only if an Explanation of Benefits (EOB) from the primary carrier is attached. The primary payer shall pay, reject, or apply the COB claim to the deductible.

4. If CalOptima or a Health Network receives a COB claim without proof of disposition (i.e., EOB or reject letter) from the primary payer, CalOptima or a Health Network shall process the claim to the Provider using the appropriate denial reason code.

C. Application of COB rules

1. If a Provider is paid a fee-for-service rate or negotiated contract fee, CalOptima or a Health Network as the secondary payer, shall pay the difference between the amount paid by the OHC, as the primary plan, and the amount CalOptima, or a Health Network, would have paid in the absence of OHC.

a. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

b. The total of the payments issued by the OHC plan and CalOptima, or a Health Network, shall not exceed the normal plan benefits of CalOptima, or a Health Network.

2. If a claim is submitted by a Provider for a Covered Service that is not covered by the primary payer, CalOptima, or a Health Network, shall require that the Provider submit a denial letter or EOB from the primary payer with the claim prior to payment consideration.

3. In the absence of proof of payment or denial of benefits, the OHC plan shall certify that the policy had terminated, and the Member was no longer eligible at the time the services were rendered.

4. The Provider may bill CalOptima or a Health Network directly for payment for elective abortions not covered by TRICARE.

5. An OHC plan indicating coverage through TRICARE, Kaiser, other pre-paid health plan (PHP) or health maintenance organization (HMO), and other organizations not contracting with CalOptima, or a Health Network, to provide services, shall pay for services prior to reimbursement consideration by CalOptima or a Health Network for those services.

6. CalOptima or a Health Network shall pay for Covered Services that are not covered by a PHP, or HMO, if the claim is accompanied by a denial letter from the PHP or HMO.

D. A Provider shall submit a claim for a Member who is eligible for both Medicare and Medi-Cal to Medicare prior to billing CalOptima or a Health Network.

1. Medicare Part A (hospital only)

For 20201119 FAC Review Only

a. If a Member has Medicare Part A only, a Provider shall submit a claim to Medicare for payment of the hospital charges and the facility or technical component fees of the ancillary charges.

b. CalOptima or a Health Network shall pay Crossover Claims for the Medicare co-insurance and the annual deductible amounts not payable by Medicare.

c. CalOptima or a Health Network shall pay the Medicare Part B component for inpatient services covered by Medicare.

d. Medicare Part A Covered Services include, but are not limited to:

i. Inpatient hospital care;

ii. Psychiatric hospital care;

iii. Skilled nursing facility;

iv. Hospice care; and

v. Respite care.

e. A Provider shall submit a Medicare RAD with the claim for payment of Medicare Part B services to CalOptima or a Health Network for payment consideration.

2. Medicare Part B (outpatient physician services)

a. If a Member has Medicare Part B only, a Provider shall submit a claim for inpatient hospital and facility charges up to the maximum allowed by CalOptima inpatient rates to CalOptima or a Health Network the primary payer for inpatient hospital and facility charges.

b. A Provider shall submit a claim for physician services and professional component fees of the hospital ancillary charges (e.g., laboratory, radiology, therapy) to Medicare, the primary payer for all physician services and professional component fees of the hospital ancillary charges.

c. CalOptima or a Health Network as the secondary payer, shall pay for the following:

i. Medicare Part A component less the Medicare payment;

ii. Medicare co-insurance; and

iii. Annual deductible amount for Medicare Part B services.

d. Medicare Part B Covered Services include, but are not limited to:

i. Physician services;

ii. Outpatient hospital treatments;

iii. Home health visits;

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iv. Inpatient and outpatient medical services and supplies;

v. Blood supplies; and

vi. Other medical and health services, including but not limited to:

1) Transportation;

2) Home dialysis equipment;

3) Oral surgery;

4) Outpatient physical therapy;

5) Speech pathology;

6) Diagnostic radiology;

7) Radiation treatments;

8) Pathology and laboratory;

9) Psychology and occupational therapy (50% payable); and

10) Limited vision.

e. A Provider shall submit claims for Medicare Part B services to Medicare Part B carriers, in accordance with the EOMB.

f. A Provider shall submit claims for Medicare Part A services to Medicare Part A carriers, in accordance with the Remittance Advice Details.

3. Medicare Part A and Part B

a. If a Member has Medicare Part A and Part B, a Provider shall submit a claim to Medicare, the primary payer.

b. CalOptima, or a Health Network, as a secondary payer, shall pay the amount billed for the Medicare co-insurance or annual deductibles for Medicare Part A, Medicare Part B, or Medicare Part A and Part B coverage.

4. If a Member who is entitled to Medicare is enrolled in a Medicare risk-sharing HMO plan, a Provider shall submit a claim to the HMO plan, the primary payer. CalOptima shall remain the secondary payer.

E. Post-Payment Recovery Reporting

1. In accordance with DHCS requirements, CalOptima and a Health Network must engage in Post-Payment Recovery if OHC is discovered retroactively or the Member had an OHC "A" indicator on the Medi-Cal eligibility record.

a. Beginning October 1, 2020, Health Networks shall submit the monthly Post-Payment Recovery Template report (Attachment C) to CalOptima as follows:

For 20201119 FAC Review Only

i. A Health Network shall submit a report for Post-Payment Recoveries by the third (3rd) calendar day of the month, or the first (1st) business day thereafter, if the third (3rd) falls on a weekend or holiday to CalOptima's FTP site. A Health Network shall submit the report using CalOptima's format and file naming convention.

ii. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than two (2) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the fifth (5th) calendar day of the following month, or the first (1st) business day if the fifth (5th) falls on a weekend or holiday. Any resubmission after the fifth (5th) business day of the calendar month will be included in the subsequent month's process.

2. CalOptima will submit detailed information regarding recoveries to include CalOptima and Health Network data to DHCS in a monthly report utilizing DHCS secure File Transfer Protocol (sFTP) no later than the fifteenth (15th) of each month using the format and file naming convention required by DHCS.

3. If CalOptima or a Health Network initiates and completes Post-Payment Recovery within twelve (12) months from the date of payment of a service, CalOptima or the Health Network is entitled to retain all monies recovered.

a. CalOptima shall remit warrants, payable to DHCS, for all recovered monies that are thirteen (13) months or older from the date of payment to the following address:

Bank of America
P.O. Box 742635
Los Angeles, CA 90074-2635.

b. DHCS Third Party Liability and Recovery Division (TPLRD) will conduct Post-Payment Recoveries and/or leverage its recovery contractor to initiate Post-Payment Recovery beginning the thirteenth (13th) month following the date of payment. Monies recovered by TPLRD will be retained by DHCS.

4. Beginning January 1, 2021, CalOptima or a Health Network shall include in the notification to the provider when a claim is denied due to the presence of OHC. Notification should include but is not limited to:

a. Name of the OHC provider;

b. Policy number; and

c. OHC contact or billing information.

~~E.~~F. In accordance with DHCS requirements, COB reports maintained by CalOptima and a Health Network shall display claim counts and dollar amounts of costs avoided and the amount of ~~post-payment recoveries~~Post- Payment Recoveries by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. CalOptima and a Health Network shall make the reports available to DHCS upon request.

IV. ATTACHMENT(S)

For 2020 1/9 FAC Review Only

A. CMS-1500 Form
B. UB-04 Form
C. Post-Payment Recovery Template Appendix B

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Coordination of Benefits Handbook, Business & Legal Resources (BLR), Copyright 2019
C. Title 22, California Code of Regulations (C.C.R), Division 3: Health Care Services, Chapter 2, Articles 12 & 15
D. Department of Health Care Services (DHCS) All Plan Letter 20-010 Cost Avoidance and Post-Payment Recovery for Other Health Coverage

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2008	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2009	FF.2003	Coordination of Benefits	Medi-Cal
Revised	10/01/2016	FF.2003	Coordination of Benefits	Medi-Cal
Revised	06/07/2018	FF.2003	Coordination of Benefits	Medi-Cal
Revised	07/01/2019	FF.2003	Coordination of Benefits	Medi-Cal
Revised	TBD	FF.2003	Coordination of Benefits	Medi-Cal

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IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Coordination of Benefits	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Cost Avoidance	Practice of requiring a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to seeking payment from the CalOptima Medi-Cal program.
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), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members ~~not withstanding~~notwithstanding whether such benefits are provided under the
Crossover Claim	A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
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.
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 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.

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Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal Obligation, excluding tort liability.
Post-Payment Recovery	All reasonable measures taken to determine the legal liability of third parties and seek reimbursement for Covered Services for which the third party is liable.
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
Share of Cost (SOC)	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.

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Policy:	FF.2003
Title:	**Coordination of Benefits**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20201119 FAC Review Only

I. PURPOSE

This policy describes the process for determining Coordination of Benefits (COB), or order of payment, for payment of Covered Services when a Member has active coverage by more than one (1) group health plan.

II. POLICY

A. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan.

B. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort.

C. If a Member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the primary health plan shall pay for the medical, other care, or treatment benefits. CalOptima and a Health Network, as a secondary health plan and payer of last resort, shall adjudicate the claim based on amounts allowed by CalOptima and the primary health plan, whichever is less.

D. If CalOptima identifies OHC unknown to the Department of Health Care Services (DHCS), the Customer Service Department shall report this information to the DHCS Third Party Liability Branch, Other Coverage Unit, within ten (10) calendar days of discovery in an automated format as prescribed by DHCS.

E. An OHC plan, as the primary health plan, shall make payment as appropriate for a Member that has received services that fall within the OHC plan's scope of coverage, or shall deny payment as non-covered benefits, prior to payment consideration by CalOptima or a Health Network.

F. If a Member has both Medicare and an OHC plan, both Medicare and the OHC plan shall pay claims for services prior to payment consideration by CalOptima or a Health Network.

G. CalOptima and a Health Network shall not consider a claim for a Member with a Medicare supplemental policy through an insurance carrier as a Medicare/Medi-Cal Crossover Claim. CalOptima and a Health Network shall consider the Medicare supplemental insurance carrier as the primary health plan and CalOptima and a Health Network as the secondary health plan and the payer of last resort.

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H. CalOptima and a Health Network shall base the COB claim determination period upon the period of time that the Member is actively eligible for Medi-Cal benefits. If there is a break in eligibility and the dates of service falls within the period of time when the Member is not covered by Medi-Cal, CalOptima and the Health Network shall not apply the COB rules to the claim.

I. CalOptima and a Health Network shall make reasonable efforts to recover the value of Covered Services, also referred to as Post-Payment Recovery, or appropriately determine payment of claims for Covered Services, also known as Cost Avoidance, rendered to a Member whenever the Member is fully or partially covered for the same service under any other State or Federal medical care program or under contractual or legal entitlement including, but not limited to, a private group or indemnification program. CalOptima shall rely only on the Medi-Cal FAME File eligibility data provided by DHCS and loaded into FACETS™ to recover such payment for OHC.

J. CalOptima and a Health Network may contract with a third-party vendor to recover any payments as described in Section II.I. of this Policy.

K. CalOptima and a Health Network shall have the right to obtain and release COB information and may do so without consent from the Member, or the Member's Authorized Representative. CalOptima and a Health Network shall require a Member to provide insurers with any information needed to make COB determinations, and to pay claims.

L. A Member shall satisfy the monthly Share of Cost (SOC) dollar amount for medical expenses prior to CalOptima certifying the Member to receive Medi-Cal benefits. Upon eligibility certification, the Medi-Cal host computer shall provide an Eligibility Verification Confirmation (EVC) number.

1. CalOptima and a Health Network shall reduce the reimbursement made to a Provider for services rendered to a Member with a SOC by the SOC amount.

2. CalOptima may require a Member with a SOC who has OHC to pay a deductible or a co-payment amount up to his or her SOC. A Provider may bill CalOptima or a Health Network the remaining balance of the deductible or co-payment amount. CalOptima shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less.

3. If a Member has no SOC obligations, a Provider may bill CalOptima or a Health Network for the co-payment or deductible amount. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less (up to the co-pay or deductible amount).

M. A Provider shall not bill or collect deductible or co-payment amounts from a Member, except as provided in Section III.L. of this Policy.

N. Medicare Crossover

1. CalOptima or a Health Network shall pay the annual deductible or co-payment amount for a Member with Medicare Part A, Medicare Part B, or Medicare Part A and Part B, as required by current regulations. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

2. CalOptima or a Health Network shall pay a deductible or co-payment for Medicare Part A acute care inpatient services for a Member, in accordance with current Medi-Cal regulations.

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O. CalOptima and a Health Network shall maintain, and on a monthly basis submit, COB reports including, but not limited to reports on Post-Payment Recovery for other health coverage, in accordance with Section III.E. of this Policy and applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance. CalOptima and its Health Networks shall retain such records for a period of at least ten (10) years after the termination of CalOptima's contract with DHCS.

III. PROCEDURE

A. CalOptima and a Health Network shall use the following indicators to assess a Member's claim for possible OHC including, but not limited to:

1. Claim forms or Provider billings:
    a. CMS-1500;
    b. UB-04;
    c. PM160 (for dates of service through June 30, 2018 only); or
    d. 25-1.
2. CalOptima or FACETS™:
    a. Health plan carrier codes; or
    b. Medi-Cal eligibility aid codes.
3. Health Network:
    a. Health plan carrier code;
    b. Medi-Cal eligibility aid codes; or
    c. Other insurance information included in the CalOptima Member Eligibility tapes or through the file transfer protocol (FTP) site.
4. Automated Eligibility Verification System (AEVS): As listed on the Supplemental to AEVS Carrier Codes for Other Health Coverage;
5. Photocopies of Remittance Advice Details (RAD);
6. Explanation of Medicare Benefits (EOMB); or
7. Explanation of Payments to Providers (EOP) from other insurance payers.

B. COB Claims Process

1. CalOptima and a Health Network shall review the submitted claim form for indication of OHC. Pursuant to CMS-1500 or UB-04 claim forms, CalOptima and a Health Network shall utilize the following questions to review the claim form including, but not limited to:

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a. *Does the bill indicate the existence of other insurance coverage*?
Universal claim forms (CMS-1500, UB-04, PM160 (for dates of service through June 30, 2018 only), 25-1) used by physicians, hospitals, and other Providers usually indicate the type of coverage and the insurance carrier and may provide the group plan name and number. (See Box 11d on CMS-1500 – Is There Another Health Benefit Plan).

b. *Has the bill been paid in part or in whole?*
An attachment to the claim submitted as evidence or explanation of benefits (EOB) may indicate that another plan has already provided benefits. (See Box 29 on CMS-1500 – Amount Paid).

c. *Is the spouse employed?*
If the spouse is employed, the Member may have coverage under the spouse's employer's group health plan. Dependent children may have coverage as dependents under the spouse's coverage. (See Box 9c on CMS-1500 – Employer's Name)

d. *Is the claimant covered by other plans that provide benefits or services?*
Claim forms usually request this information, along with the type of coverage, the name of the insurance carrier, and the group number. (See Box 9a-d on CMS-1500 – Other Insured's Name and Insurance Information)

e. *If the claimant is a child, does the last name differ from that of the insured or covered Member?*
This may indicate coverage through a second parent or a divorce situation in which natural and stepparents cover the child.

f. *Does the claim form indicate that the employee has a former employer?*
This may indicate that the claimant is receiving coverage as a retiree under the former employer's group health plan.

g. *Does the claim form indicate that the claimant is covered under the State or Federal health insurance continuation program?*
This may indicate coverage under a former employer's group health plan (e.g., COBRA).

h. *Is the claimant age sixty-five (65) or older?*
This may indicate the presence of Medicare coverage. (See Box 1 if the Medicare Box is checked and Box 3 on CMS-1500 – Patient's Birth Date)

i. *Is the claimant under age sixty-five (65) and diagnosed with end-stage renal disease (ESRD)?*
This may indicate that the claimant is entitled to Medicare coverage.

j. *If the claim was the result of an accident, where and how did it occur?*
This may indicate that the medical expenses are covered by a Third-Party Liability carrier, such as auto insurance or a homeowner's policy. (See Box 10b on CMS-1500 – Is Patient's Condition Related to Auto Accident or Box 21 on CMS-1500 – Description of Injury)

k. *Were the bills submitted as photocopies?*
This may indicate that the original bills were sent to another health plan carrier for payment.

l. *Were copies of the other carrier's evidence or explanation of benefits or payment submitted instead of the Provider's itemized bill?*
This usually indicates that the claimant has OHC.

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m. *Does the system identify health plan carrier codes as evidence of OHC?*
If available, the Health Network information system should flag the claim for identification of OHC.

2. CalOptima or a Health Network shall not process a COB claim until the primary plan adjudicates the claim or OHC is verified.

3. CalOptima or a Health Network shall process a COB claim only if an Explanation of Benefits (EOB) from the primary carrier is attached. The primary payer shall pay, reject, or apply the COB claim to the deductible.

4. If CalOptima or a Health Network receives a COB claim without proof of disposition (i.e., EOB or reject letter) from the primary payer, CalOptima or a Health Network shall process the claim to the Provider using the appropriate denial reason code.

C. Application of COB rules

1. If a Provider is paid a fee-for-service rate or negotiated contract fee, CalOptima or a Health Network as the secondary payer, shall pay the difference between the amount paid by the OHC, as the primary plan, and the amount CalOptima, or a Health Network, would have paid in the absence of OHC.

a. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

b. The total of the payments issued by the OHC plan and CalOptima, or a Health Network, shall not exceed the normal plan benefits of CalOptima, or a Health Network.

2. If a claim is submitted by a Provider for a Covered Service that is not covered by the primary payer, CalOptima, or a Health Network, shall require that the Provider submit a denial letter or EOB from the primary payer with the claim prior to payment consideration.

3. In the absence of proof of payment or denial of benefits, the OHC plan shall certify that the policy had terminated, and the Member was no longer eligible at the time the services were rendered.

4. The Provider may bill CalOptima or a Health Network directly for payment for elective abortions not covered by TRICARE.

5. An OHC plan indicating coverage through TRICARE, Kaiser, other pre-paid health plan (PHP) or health maintenance organization (HMO), and other organizations not contracting with CalOptima, or a Health Network, to provide services, shall pay for services prior to reimbursement consideration by CalOptima or a Health Network for those services.

6. CalOptima or a Health Network shall pay for Covered Services that are not covered by a PHP, or HMO, if the claim is accompanied by a denial letter from the PHP or HMO.

D. A Provider shall submit a claim for a Member who is eligible for both Medicare and Medi-Cal to Medicare prior to billing CalOptima or a Health Network.

1. Medicare Part A (hospital only)

For 20201119 FAC Review Only

a. If a Member has Medicare Part A only, a Provider shall submit a claim to Medicare for payment of the hospital charges and the facility or technical component fees of the ancillary charges.

b. CalOptima or a Health Network shall pay Crossover Claims for the Medicare co-insurance and the annual deductible amounts not payable by Medicare.

c. CalOptima or a Health Network shall pay the Medicare Part B component for inpatient services covered by Medicare.

d. Medicare Part A Covered Services include, but are not limited to:

i. Inpatient hospital care;

ii. Psychiatric hospital care;

iii. Skilled nursing facility;

iv. Hospice care; and

v. Respite care.

e. A Provider shall submit a Medicare RAD with the claim for payment of Medicare Part B services to CalOptima or a Health Network for payment consideration.

2. Medicare Part B (outpatient physician services)

a. If a Member has Medicare Part B only, a Provider shall submit a claim for inpatient hospital and facility charges up to the maximum allowed by CalOptima inpatient rates to CalOptima or a Health Network the primary payer for inpatient hospital and facility charges.

b. A Provider shall submit a claim for physician services and professional component fees of the hospital ancillary charges (e.g., laboratory, radiology, therapy) to Medicare, the primary payer for all physician services and professional component fees of the hospital ancillary charges.

c. CalOptima or a Health Network as the secondary payer, shall pay for the following:

i. Medicare Part A component less the Medicare payment;

ii. Medicare co-insurance; and

iii. Annual deductible amount for Medicare Part B services.

d. Medicare Part B Covered Services include, but are not limited to:

i. Physician services;

ii. Outpatient hospital treatments;

iii. Home health visits;

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iv. Inpatient and outpatient medical services and supplies;

v. Blood supplies; and

vi. Other medical and health services, including but not limited to:

1) Transportation;

2) Home dialysis equipment;

3) Oral surgery;

4) Outpatient physical therapy;

5) Speech pathology;

6) Diagnostic radiology;

7) Radiation treatments;

8) Pathology and laboratory;

9) Psychology and occupational therapy (50% payable); and

10) Limited vision.

e. A Provider shall submit claims for Medicare Part B services to Medicare Part B carriers, in accordance with the EOMB.

f. A Provider shall submit claims for Medicare Part A services to Medicare Part A carriers, in accordance with the Remittance Advice Details.

3. Medicare Part A and Part B

a. If a Member has Medicare Part A and Part B, a Provider shall submit a claim to Medicare, the primary payer.

b. CalOptima, or a Health Network, as a secondary payer, shall pay the amount billed for the Medicare co-insurance or annual deductibles for Medicare Part A, Medicare Part B, or Medicare Part A and Part B coverage.

4. If a Member who is entitled to Medicare is enrolled in a Medicare risk-sharing HMO plan, a Provider shall submit a claim to the HMO plan, the primary payer. CalOptima shall remain the secondary payer.

E. Post-Payment Recovery Reporting

1. In accordance with DHCS requirements, CalOptima and a Health Network must engage in Post-Payment Recovery if OHC is discovered retroactively or the Member had an OHC "A" indicator on the Medi-Cal eligibility record.

a. Beginning October 1, 2020, Health Networks shall submit the monthly Post-Payment Recovery Template report (Attachment C) to CalOptima as follows:

For 20201119 FAC Review Only

i. A Health Network shall submit a report for Post-Payment Recoveries by the third (3rd) calendar day of the month, or the first (1st) business day thereafter, if the third (3rd) falls on a weekend or holiday to CalOptima's FTP site. A Health Network shall submit the report using CalOptima's format and file naming convention.

ii. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than two (2) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the fifth (5th) calendar day of the following month, or the first (1st) business day if the fifth (5th) falls on a weekend or holiday. Any resubmission after the fifth (5th) business day of the calendar month will be included in the subsequent month's process.

2. CalOptima will submit detailed information regarding recoveries to include CalOptima and Health Network data to DHCS in a monthly report utilizing DHCS secure File Transfer Protocol (sFTP) no later than the fifteenth (15th) of each month using the format and file naming convention required by DHCS.

3. If CalOptima or a Health Network initiates and completes Post-Payment Recovery within twelve (12) months from the date of payment of a service, CalOptima or the Health Network is entitled to retain all monies recovered.

   a. CalOptima shall remit warrants, payable to DHCS, for all recovered monies that are thirteen (13) months or older from the date of payment to the following address:

      Bank of America
      P.O. Box 742635
      Los Angeles, CA 90074-2635.

   b. DHCS Third Party Liability and Recovery Division (TPLRD) will conduct Post-Payment Recoveries and/or leverage its recovery contractor to initiate Post-Payment Recovery beginning the thirteenth (13th) month following the date of payment. Monies recovered by TPLRD will be retained by DHCS.

4. Beginning January 1, 2021, CalOptima or a Health Network shall include in the notification to the provider when a claim is denied due to the presence of OHC. Notification should include but is not limited to:

   a. Name of the OHC provider;

   b. Policy number; and

   c. OHC contact or billing information.

F. In accordance with DHCS requirements, COB reports maintained by CalOptima and a Health Network shall display claim 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. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. CalOptima and a Health Network shall make the reports available to DHCS upon request.

IV. ATTACHMENT(S)

For 2020 1 19 FAC Review Only

A. CMS-1500 Form
B. UB-04 Form
C. Post-Payment Recovery Template Appendix B

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Coordination of Benefits Handbook, Business & Legal Resources (BLR), Copyright 2019
C. Title 22, California Code of Regulations (C.C.R), Division 3: Health Care Services, Chapter 2, Articles 12 & 15
D. Department of Health Care Services (DHCS) All Plan Letter 20-010 Cost Avoidance and Post-Payment Recovery for Other Health Coverage

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2008	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2009	FF.2003	Coordination of Benefits	Medi-Cal
Revised	10/01/2016	FF.2003	Coordination of Benefits	Medi-Cal
Revised	06/07/2018	FF.2003	Coordination of Benefits	Medi-Cal
Revised	07/01/2019	FF.2003	Coordination of Benefits	Medi-Cal
Revised	TBD	FF.2003	Coordination of Benefits	Medi-Cal

For 20201119 FAC Review Only

IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Coordination of Benefits	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Cost Avoidance	Practice of requiring a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to seeking payment from the CalOptima Medi-Cal program.
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 Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Crossover Claim	A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
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.
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 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.

For 2020 UFAC Review Only

Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal Obligation, excluding tort liability.
Post-Payment Recovery	All reasonable measures taken to determine the legal liability of third parties and seek reimbursement for Covered Services for which the third party is liable.
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.
Share of Cost (SOC)	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.

For 20201119 FAC Review Only

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

SAMPLE

Back to Agenda Back to Item

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

CONDITION CODES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO.

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APPENDIX B

Field Name	Format	Field Description
Project Type	Text	(Third Party Liability (TPL), Credit Balance Audit, Retro Eligibility, Medicaid Fraud Control Unit, Professional Practice Insurance Broker, Other)
Provider Name	Text	(Institutional= Facility Name, Professional = Rendering Name)
Provider TIN	Text	Provider Federal Tax ID Number
Claim Type	Text	(Inst, Prof, Pharmacy, Dental)
Medicaid Number	Text	Recipient Identification Number
Recipient SS#	Numeric	Recipient Social Security Number (leave blank if unknown)
Client First name	General	Client First name
Client Last name	General	Client Last name
Date of Birth	MM-DD-YYYY	Recipient Date of Birth
TCN	TEXT	Managed Care health plan (MCP) Claim Transaction Control Number
Begin DOS	MM-DD-YYYY	Begin date of service
End DOS	MM-DD-YYYY	End date of service
CCO Bill amount	Currency	Coordinated Care Organization (CCO) Amount billed to TPL
CCO Paid amount	Currency	CCO Amount MCP paid to the Provider
Bill date	MM-DD-YYYY	Date the claim was billed to the TPL
Remit amount	Currency	Amount Recovered from TPL
Claim date of remit	MM-DD-YYYY	Date the claim was paid or denied by TPL (leave blank if claims is open)
Check Number	General	Check number
Other Insurance carrier name	General	Name of TPL that was billed
Claim status	General	Disposition of claims (Paid, Denied, Open, etc)
Denial Reason	General	The reason the claim was denied

1) File should be uploaded to the Department of Health Care Services Secure File Transfer Protocol (SFTP) no later than the 15th of each month.
2) File should be in xlsx format.
3) Files should have the following naming convention MCPPR."MCP Short Name"_YYYY_MM_DD.xslx

Please see below for a list of MCP Short Names and file naming conventions.

4) MCP contract representatives will be sent a username and password to access the SFTP prior to May 1, 2020

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APPENDIX B

MCP Full Name	MCP Short Name	SFTP File Naming Convention
Aetna	Aetna	MCPPR.Aetna_YYYY_MM_DD.xslx
AIDS Health Foundation	AHF	MCPPR.AHF_YYYY_MM_DD.xslx
Alameda Alliance for Health	AAH	MCPPR.AAH_YYYY_MM_DD.xslx
Anthem Blue Cross	ABC	MCPPR.ABC_YYYY_MM_DD.xslx
Blue Shield Promise	BSP	MCPPR.BSP_YYYY_MM_DD.xslx
California Health and Wellness	CHW	MCPPR.CHW_YYYY_MM_DD.xslx
CalOptima	CO	MCPPR.CO_YYYY_MM_DD.xslx
CalViva Health Plan	CVHP	MCPPR.CVHP_YYYY_MM_DD.xslx
CenCal	CenCal	MCPPR.CenCal_YYYY_MM_DD.xslx
Central CA Alliance for Health	CCAH	MCPPR.CCAH_YYYY_MM_DD.xslx
Community Health Group	CHG	MCPPR.CHG_YYYY_MM_DD.xslx
Contra Costa Health Plan	CCHP	MCPPR.CCHP_YYYY_MM_DD.xslx
Family Mosaic	FM	MCPPR.FM_YYYY_MM_DD.xslx
Gold Coast Health Plan	GCHP	MCPPR.GHCP_YYYY_MM_DD.xslx
Health Net	HN	MCPPR.HN_YYYY_MM_DD.xslx
Health Plan of San Mateo	HPSM	MCPPR.HPSM_YYYY_MM_DD.xslx
Health Plan San Joaquin	HPSJ	MCPPR.HPSJ_YYYY_MM_DD.xslx
Healthy San Diego	HSD	MCPPR.HSD_YYYY_MM_DD.xslx
Inland Empire Health Plan	IEHP	MCPPR.IEHP_YYYY_MM_DD.xslx
Kaiser Permanente	KP	MCPPR.KP_YYYY_MM_DD.xslx
Kern Health Systems	KHS	MCPPR.KHS_YYYY_MM_DD.xslx
LA Care	LACare	MCPPR.LACare_YYYY_MM_DD.xslx
Molina	Molina	MCPPR.Molina_YYYY_MM_DD.xslx
Partnership Health Plan	PHP	MCPPR.PHP_YYYY_MM_DD.xslx
Rady	Rady	MCPPR.Rady_YYYY_MM_DD.xslx
San Francisco Health Plan	SFHP	MCPPR.SFHP_YYYY_MM_DD.xslx
Santa Clara Family Health Plan	SCFHP	MCPPR.SCFHP_YYYY_MM_DD.xslx
SCAN	SCAN	MCPPR.SCAN_YYYY_MM_DD.xslx
United Healthcare	UHC	MCPPR.UHC_YYYY_MM_DD.xslx

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Policy:	FF.2005
Title:	**Conlan, Member Reimbursement**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes CalOptima's process to comply with the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, the court-ordered reimbursement process to Members for paid out-of-pocket expenses for Medi-Cal Covered Services.

II. POLICY

A. CalOptima, in compliance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, and in accordance with applicable state and federal regulations, shall reimburse Members for out-of-pocket expenses for Covered Services through the terms and conditions of this Policy.

B. If CalOptima or a Health Network denies all or part of the Member's claim, the Member shall have the right to appeal the decision in accordance with CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~.

C. Providers and Practitioners shall have the option to file a State Hearing and provide evidence that the proposed reimbursement and recoupment is not correct for *Conlan* claims only.

D. CalOptima may recoup from Health Networks, Providers, and Practitioners to reimburse a Member in accordance to the provisions set forth in this Policy.

E. CalOptima, its Health Networks, Providers, and Practitioners shall not submit claims to, or demand, or otherwise collect reimbursement from, a Member, in accordance to Title 22, California Code of Regulations, Section 51002.

F. CalOptima shall report and investigate any suspected Fraud, Waste, and Abuse matters, pursuant to CalOptima Policies HH.1105Δ: Fraud and Abuse Detection and HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting.

G. If a Member does not fully comply with the provisions set forth in this Policy, CalOptima may deny the Member's claim.

III. PROCEDURE

For 20201119 FAC Review Only

A. Subject to the provisions of this Policy, and in accordance with the MMCD All Plan Letter 07-002, CalOptima shall reimburse a Member for paid out-of-pocket expenses for Covered Services received on and after June 27, 1997, during the following specific periods of a Member's eligibility:

1. The post-approval period (the time period after eligibility has been established).

~~B.~~ CalOptima and its Health Networks shall only be responsible to provide reimbursement for Covered Services for which CalOptima and its Health Networks receive Capitation Payment, subject to all applicable CalOptima and Health Network utilization protocols, policies, and procedures as of the date of service, including, but not limited to:

~~C.~~

~~Pharmacy limits, as set forth in CalOptima Policy GG.1413: Polypharmacy Management;~~

~~Pharmacy Home Program, as set forth in CalOptima Policy GG.1416: Pharmacy Home Program;~~

B.

1. Pharmacy limits, as set forth in CalOptima Policy GG.1413: Polypharmacy Management for dates of service on or before December 31, 2020;

2. Pharmacy Home Program, as set forth in CalOptima Policy GG.1416: Pharmacy Home Program for dates of service on or before December 31, 2020;

~~1.~~3. Utilization Management controls and limitations, as set forth in CalOptima Policy GG.1508: Authorization and Processing of Referrals;

~~2.~~4. Non-emergency transportation, as set forth in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical;

~~3.~~5. Disposable incontinence supplies, as set forth in CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies; and

~~4.~~6. Durable Medical Equipment (DME), as set forth in CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs.

C. CalOptima and its Health Networks are not obligated to provide reimbursement for the following services:

1. Carved-Out Services (i.e., Medi-Cal services for which CalOptima and its Health Networks are not responsible);

2. Services rendered to a Member during a time period outside of those specified in Section III.A. of this Policy;

3. Services for which pre-authorization was required but not obtained, in accordance to CalOptima Policy GG.1508: Authorization and Processing of Referrals;

4. Services for which a Member went out-of-network to receive non-emergency services; and

5. Services that were rendered by a Provider or Practitioner who does not have a valid Medi-Cal Provider number.

For 20201119 FAC Review Only

D. CalOptima shall adjudicate *Conlan* reimbursement claims within one hundred twenty (120) calendar days after CalOptima's receipt of a completed claim packet from the Department of Health Care Services (DHCS) or its agent for CalOptima-covered expenses incurred and paid during the time periods referenced in Section III.A. of this Policy. Excluded from the *Conlan* Adjudication Period are the time periods between mailing of a notice to a Member that additional information is required to process a claim, and receipt of such information, and any period during which a recoupment action is in effect against the Provider who owes a reimbursement.

IV. ATTACHMENT(S)

A. Provider Notice A: CalOptima Requests Medi-Cal Provider to Reimburse the Member
B. Provider Notice B: CalOptima Requests Non-Medi-Cal Provider to Reimburse the Member
C. Provider Notice C: Provider Obligation to Reimburse Member and Submit Claim to CalOptima
D. Member Notice A: Claim Closed due to Full Reimbursement from Provider
E. Member Notice B: Additional Information Required to Process Claim
F. Member Notice C: Claim Denial
G. Member Notice D: Direct Reimbursement from CalOptima to Member for Medi-Cal Rate
H. Member Notice E: Confirmation of Receipt of Claim

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy HH.1105Δ: Fraud and Abuse Detection
C. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
D. CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies
~~E. CalOptima Policy GG.1413: Polypharmacy Management~~CalOptima Policy GG.1413: Polypharmacy Management
~~F.~~E. ~~CalOptima Policy GG.1416: Pharmacy Home Program~~
~~G.~~F. CalOptima Policy GG.1416: Pharmacy Home Program
~~H.~~
~~I.~~G. CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
~~J.~~H. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
~~K.~~I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~L.~~J. CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~
~~M.~~K. Department of Health Care Services (DHCS) Notice to Medi-Cal beneficiaries
L. Department of Health Care Services (DHCS) Notice to Medi-Cal Rx: Post Transition roles & Responsibilities
~~N.~~M. Department of Health Care Services (DHCS) All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process
~~O.~~N. Title 22, California Code of Regulations (CCR), Section 51002

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

For 2020 1119 FAC Review Only

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	07/01/2009	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	03/01/2012	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	10/01/2016	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2017	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2018	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	05/01/2019	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	TBD	FF.2005	Conlan, Member Reimbursement	Medi-Cal

For 20201119 FAC Review Only

IX. GLOSSARY

Term	Definition
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
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 ~~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), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members ~~not withstandingnotwithstanding~~ whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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.
Durable Medical Equipment (DME)	Any equipment, other than prosthetic or orthotic appliances, that is prescribed by a licensed Practitioner to meet the medical equipment needs of the Member that: 1. Can withstand repeated use; 2. Is used to serve a medical purpose; 3. Is not useful to a Member in the absence of an illness, injury, functional impairment or congenital anomaly; and 4. Is appropriate for use in or outside of the Member's home.
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 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.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation 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 the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.

For 2020 1/9 FAC Review Only

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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.

1

For 20201119 FAC Review Only

Policy:	FF.2005
Title:	**Conlan, Member Reimbursement**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20201119 FAC Review Only

I. PURPOSE

This policy establishes CalOptima's process to comply with the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, the court-ordered reimbursement process to Members for paid out-of-pocket expenses for Medi-Cal Covered Services.

II. POLICY

A. CalOptima, in compliance with Medi-Cal Managed Care Division (MMCD) All Plan Letter 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, and in accordance with applicable state and federal regulations, shall reimburse Members for out-of-pocket expenses for Covered Services through the terms and conditions of this Policy.

B. If CalOptima or a Health Network denies all or part of the Member's claim, the Member shall have the right to appeal the decision in accordance with CalOptima Policy GG.1510: Appeal Process.

C. Providers and Practitioners shall have the option to file a State Hearing and provide evidence that the proposed reimbursement and recoupment is not correct for *Conlan* claims only.

D. CalOptima may recoup from Health Networks, Providers, and Practitioners to reimburse a Member in accordance to the provisions set forth in this Policy.

E. CalOptima, its Health Networks, Providers, and Practitioners shall not submit claims to, or demand, or otherwise collect reimbursement from, a Member, in accordance to Title 22, California Code of Regulations, Section 51002.

F. CalOptima shall report and investigate any suspected Fraud, Waste, and Abuse matters, pursuant to CalOptima Policies HH.1105Δ: Fraud and Abuse Detection and HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting.

G. If a Member does not fully comply with the provisions set forth in this Policy, CalOptima may deny the Member's claim.

III. PROCEDURE

A. Subject to the provisions of this Policy, and in accordance with the MMCD All Plan Letter 07-002, CalOptima shall reimburse a Member for paid out-of-pocket expenses for Covered Services received on and after June 27, 1997, during the following specific periods of a Member's eligibility:

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1. The post-approval period (the time period after eligibility has been established).

B. CalOptima and its Health Networks shall only be responsible to provide reimbursement for Covered Services for which CalOptima and its Health Networks receive Capitation Payment, subject to all applicable CalOptima and Health Network utilization protocols, policies, and procedures as of the date of service, including, but not limited to:

1. Pharmacy limits, as set forth in CalOptima Policy GG.1413: Polypharmacy Management for dates of service on or before December 31, 2020;

2. Pharmacy Home Program, as set forth in CalOptima Policy GG.1416: Pharmacy Home Program for dates of service on or before December 31, 2020;

3. Utilization Management controls and limitations, as set forth in CalOptima Policy GG.1508: Authorization and Processing of Referrals;

4. Non-emergency transportation, as set forth in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical;

5. Disposable incontinence supplies, as set forth in CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies; and

6. Durable Medical Equipment (DME), as set forth in CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs.

C. CalOptima and its Health Networks are not obligated to provide reimbursement for the following services:

1. Carved-Out Services (i.e., Medi-Cal services for which CalOptima and its Health Networks are not responsible);

2. Services rendered to a Member during a time period outside of those specified in Section III.A. of this Policy;

3. Services for which pre-authorization was required but not obtained, in accordance to CalOptima Policy GG.1508: Authorization and Processing of Referrals;

4. Services for which a Member went out-of-network to receive non-emergency services; and

5. Services that were rendered by a Provider or Practitioner who does not have a valid Medi-Cal Provider number.

D. CalOptima shall adjudicate *Conlan* reimbursement claims within one hundred twenty (120) calendar days after CalOptima's receipt of a completed claim packet from the Department of Health Care Services (DHCS) or its agent for CalOptima-covered expenses incurred and paid during the time periods referenced in Section III.A. of this Policy. Excluded from the *Conlan* Adjudication Period are the time periods between mailing of a notice to a Member that additional information is required to process a claim, and receipt of such information, and any period during which a recoupment action is in effect against the Provider who owes a reimbursement.

IV. ATTACHMENT(S)

For 20201119 FAC Review Only

A. Provider Notice A: CalOptima Requests Medi-Cal Provider to Reimburse the Member
B. Provider Notice B: CalOptima Requests Non-Medi-Cal Provider to Reimburse the Member
C. Provider Notice C: Provider Obligation to Reimburse Member and Submit Claim to CalOptima
D. Member Notice A: Claim Closed due to Full Reimbursement from Provider
E. Member Notice B: Additional Information Required to Process Claim
F. Member Notice C: Claim Denial
G. Member Notice D: Direct Reimbursement from CalOptima to Member for Medi-Cal Rate
H. Member Notice E: Confirmation of Receipt of Claim

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy HH.1105Δ: Fraud and Abuse Detection
C. CalOptima Policy HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
D. CalOptima Policy GG.1114: Authorization for Disposable Incontinence Supplies
E. CalOptima Policy GG.1413: Polypharmacy Management
F. CalOptima Policy GG.1416: Pharmacy Home Program
G. CalOptima Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
H. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy GG.1510: Appeal Process
K. Department of Health Care Services (DHCS) Notice to Medi-Cal beneficiaries
L. Department of Health Care Services (DHCS) Notice to Medi-Cal Rx: Post Transition roles & Responsibilities
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process
N. Title 22, California Code of Regulations (CCR), Section 51002

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	07/01/2009	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	03/01/2012	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	10/01/2016	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2017	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2018	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	05/01/2019	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	TBD	FF.2005	Conlan, Member Reimbursement	Medi-Cal

For 20201119 FAC Review Only

IX. GLOSSARY

Term	Definition
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
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 Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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.
Durable Medical Equipment (DME)	Any equipment, other than prosthetic or orthotic appliances, that is prescribed by a licensed Practitioner to meet the medical equipment needs of the Member that: 1. Can withstand repeated use; 2. Is used to serve a medical purpose; 3. Is not useful to a Member in the absence of an illness, injury, functional impairment or congenital anomaly; and 4. Is appropriate for use in or outside of the Member's home.
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 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.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation 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 the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.

For 20201119 EAC Review Only

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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.

1

For 20201119 FAC Review Only

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number: _____

Dear Dr. NAME:

This letter is regarding a beneficiary reimbursement claim filed by a Medi-Cal beneficiary, (Beneficiary Name). He/She claims he/she was seen in your office on mm/dd/yy and mm/dd/yy and has provided documentation of his/her payment to you in the amount of $xxx.xx.

(Beneficiary Name) was eligible for Medi-Cal on the date(s) of service listed above. As a Medi-Cal provider, you are required to reimburse the beneficiary for the payments he/she made to you for the services. The beneficiary has reported that you have not made payment for the amount he/she paid you for the service(s).

In order to avoid an action by CalOptima to withhold these funds against future payments owed to you, you must immediately make payment to the beneficiary. The payment must be for the full amount made to you for the service(s). Once you have made payment to the beneficiary, you may submit a claim to CalOptima for reimbursement of these services. Reimbursement payment to the beneficiary should be mailed to:

Beneficiary Name
Beneficiary Address
Beneficiary Address

You must make payment to the beneficiary for the full amount of their out of pocket payment made to you. Failure to do this will result in CalOptima taking action to withhold the funds from future payments owed to you. If you have already made full payment to the beneficiary, or if you are in the process of sending this payment, please submit proof of payment with the attached Proof of Payment Form. This response should include the amount paid and the date it was paid. A response with your action must be received within 30 days from the date at the top of this letter. All correspondence should be sent to the following address:

CalOptima
Attn: Claims Administration
505 City Parkway West
Orange, CA 92868

Billing timeliness limitations for claims submissions (pursuant to Title 42 Code of Federal Regulations, section 447.45(d)(1) and California Code of Regulations (CCR), Title 22, Division 3, sections 51000.8(a) and 51008.5) will not apply due to good cause (pursuant to CCR, Title 22, Division 3, section 51008(a)) for the above claim for 60 days from the date of this letter. To request reimbursement from CalOptima for the services you provided, you must submit a claim within 60 days from the date of this letter. Submit an original claim and supporting documentation along with a copy of this letter to CalOptima Claims Administration at the address listed above.

You may disagree with this decision. If you do disagree and wish to dispute this claim, you may request a State Hearing. Information for a State Hearing is enclosed with this notice.

For more information on this matter, please call the Claims Customer Service Center at (714) 246-8885.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3.
Provider Notice A

PROOF OF PAYMENT FORM

Beneficiary Name
Beneficiary CIN Number
Provider Name

Please provide the following information to CalOptima as proof of payment to member/beneficiary for reimbursement of your services.

Proof of payment would be one of the following:

- Cash Receipt signed by patient
- Cancelled check showing payment to member/benficiary

Return this form with attachments and proof of payment to:

CalOptima
Attn: Claims Administration
505 City Parkway West
Orange, CA 92868

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

YOUR HEARING RIGHTS

You have a right to ask for a State Hearing about this Medi-Cal action. You must ask for a State Hearing within 30 days of the date this notice was mailed to you.

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

Beneficiary Service Center
P.O. Box 138008
Sacramento, CA 95813-8008

You have the right to examine the materials that were used to take this Medi-Cal action and may arrange this by contacting the Beneficiary Service Center at (916) 403-2007. For TDD service call (916) 635-6491.

STATE REGULATIONS AVAILABLE

State regulations, including those covering State Hearings, are available at your local county welfare office or on the Internet at www.calregs.com.

AUTHORIZED REPRESENTATIVE

You can represent yourself at the State Hearing. You must provide the name, address, and phone number of the person within your business entity that will represent you prior to the hearing. You can also be represented by an attorney. You must arrange for this representative yourself.

Note: The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete.

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

☐ I would like to request a State Hearing.

The reason I want a hearing is:_____
_____
_____
_____

☐ Check here and add a page if you need more space.

Provider's Name: (print)
_____
Provider's Nine Digit Medi-Cal Number:
_____
Provider's Business Address: (print)
_____
_____
Provider's Phone Number: (_____) _____
Beneficiary Reimbursement Reference No.
_____

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name:_____
Address:_____
_____

Phone number: (_____)_____

My signature (provider):

X_____

Date signed: _____

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DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number: _____

Dear Mr. NAME:

This letter is about a claim submitted by a Medi-Cal beneficiary, NAME. He/She claims to have been seen in your office on mm/dd/yy and mm/dd/yy. He/She has provided Medi-Cal with proof of his/her payment to you for those services in the amount of $xxx.xx.

NAME was eligible for Medi-Cal on the date(s) of service listed above. Medi-Cal reimburses enrolled medical providers for services rendered to Medi-Cal eligible beneficiaries. Medi-Cal eligible beneficiaries should not bear the burden of reimbursing providers for Medi-Cal covered services. Medi-Cal wants to pay you, the provider, for the services you rendered to NAME, allowing you to refund any payments made by NAME.

Our records show that you are not enrolled in the Medi-Cal Program. In order for CalOptima to pay for the services you provided, you need to enroll in the Medi-Cal program. Medi-Cal requests that you refund to NAME the amount of $**XXX.XX**, and upon enrollment in the Medi-Cal program, that you submit a claim to CalOptima for reimbursement for the services you provided. You can receive an enrollment application by calling the Telephone Service Center at 1-800-541-5555. Select options 15 and then 13. You can also download the application online at the Provider Enrollment page on the Medi-Cal Web site, www.Medi-Cal.ca.gov. When submitting your enrollment application, please include a copy of this letter on the very top of the application package. The enrollment application package must be submitted within 90 days of the date on the top of this notice in order for CalOptima to process the claim and reimburse you, the provider.

When enrolled, you may submit a claim for the above services with a copy of this letter within 90 days of the date on the notice that you have been enrolled, otherwise known as the Welcome to Medi-Cal letter. In order to avoid cutbacks in payment or denial due to the length of time since the service was provided, you must submit your claim within 90 days of the date of the Welcome to Medi-Cal letter and include a copy of this letter with the claim

Reimbursement payment to the beneficiary should be mailed to:

Beneficiary Name
Beneficiary Address
Beneficiary Address

You may disagree with this decision or disagree with any of the facts of the claim. If you dispute any facts regarding the claim, please submit your dispute in writing, including any supporting documentation, along with a copy of this letter within 30 days of the date on this letter.

Please send proof of payment or a written dispute within 30 days of the date of this letter. If you wish to enroll as a provider in the Medi-Cal program and be reimbursed for these services, please send a notice of your desire to enroll in the Medi-Cal program within 30 days of this letter. Please include a copy of this letter with any correspondence you send.

Mail your desire to enroll as a provider in the Medi-Cal program to the following address:

Beneficiary Service Center
PO Box 138008
Sacramento, CA 95813-8008

Proof of payment or disputes may be mailed to the following address:

CalOptima OneCare
Attn: Claims Administration
505 City Parkway West
Orange, CA 92868

For more information on this matter, please call the Claims Customer Service Center at (714) 246-8885.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3.
Provider Notice B

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

YOUR HEARING RIGHTS

You have a right to ask for a State Hearing about this Medi-Cal action. You must ask for a State Hearing within 30 days of the date this notice was mailed to you.

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

Beneficiary Service Center
P.O. Box 138008
Sacramento, CA 95813-8008

You have the right to examine the materials that were used to take this Medi-Cal action and may arrange this by contacting the Beneficiary Service Center at (916) 403-2007. For TDD service call (916) 635-6491.

STATE REGULATIONS AVAILABLE

State regulations, including those covering State Hearings, are available at your local county welfare office or on the Internet at www.calregs.com.

AUTHORIZED REPRESENTATIVE

You can represent yourself at the State Hearing. You must provide the name, address, and phone number of the person within your business entity who will represent you prior to the hearing. You can also be represented by an attorney. You must arrange for this representative yourself.

Note: The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete.

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

☐ I would like to request a State Hearing.

The reason I want a hearing is:_____
_____
_____
_____

☐ Check here and add a page if you need more space.

Provider's Name: (print)
_____
Provider's Nine Digit Medi-Cal Number:
_____
Provider's Business Address: (print)
_____
_____
Provider's Phone Number: (_____) _____
Beneficiary Reimbursement Reference No.
_____

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name:_____
Address:_____
_____

Phone number: (_____)_____

My signature (provider):

X_____

Date signed: _____

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Provider Notice C

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number: _____

Dear Mr./Ms. NAME:

On [DATE OF FIRST NOTICE], CalOptima provided notice to you that it had received a beneficiary reimbursement claim from [MEMBER NAME], relative to the following dates of service: [DATE(S) OF SERVICE], in the amount of [CLAIM AMOUNT]. That notice also informed you that failure to pay would result in CalOptima recouping that amount from future payments owed to you by CalOptima, and of your rights to a State Hearing as to both the amount and the right of CalOptima to recoup those funds.

As of [DATE OF THIS LETTER], the period for filing a State Hearing has expired, and both the amount of the claim and CalOptima's right to recoup that amount if it remains unreimbursed to the Member will be presumed to be correct. You may avoid a recoupment action by CalOptima by providing proof of payment with the attached Proof of Payment Form, within fourteen (14) calendar days of the date of this letter. Failure to provide such proof of payment shall result in CalOptima setting off any amounts payable to you beginning on the date of this letter against the above claim amount until the full amount of the reimbursement claim has been obtained.

Please refer to the initial notice, attached for your reference, regarding where to send the reimbursement payments, and the timeliness requirements for claims to CalOptima relative to the services for which the Member reimbursement have been paid.

For more information on this matter, please call the Claims Customer Service Center at (714) 245-8669.

Sincerely,

[NAME]
[TITLE]

Enclosures
- Previous Notice
- Proof of Payment Form

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payment(s) you made for medical care. Medi-Cal forwarded your request to CalOptima for review. CalOptima administers Medi-Cal for Orange County.

[Provider Name] informed us that on MM/DD/YY they reimbursed you in the amount of $XXX.XX. Since that reimbursement payment resolved your claim, we closed your case.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

If you have any questions, please call CalOptima Customer Service at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3Member Notice A

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payment(s) you made for medical care. Medi-Cal forwarded your request to CalOptima for review. CalOptima administers Medi-Cal for Orange County.

CalOptima is not able to process your claim because required information is missing. We need the following information to process your claim:

- ☐ Proof of payment (such as a credit card receipt, cash receipt or cancelled check)
- ☐ Itemized bill from the health care provider that lists the services you received (the bill needs to list the specific billing codes)
- ☐ Name of health care provider who provided the services (the name is missing from the itemized bill)

Please send the needed information to:

CalOptima
Attn: Claims Administration
505 City Parkway West
Orange, CA 92868

CalOptima cannot process your claim until we receive the required information. We must receive the required information no later than 45 days from the date at the top of this letter, or we will deny your claim.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

If you have any questions, please call CalOptima Customer Service department at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3
Member Notice B

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payment(s) you made for medical care. Medi-Cal forwarded your request to CalOptima for review. CalOptima administers Medi-Cal for Orange County.

Your claim has been denied for the following reason(s);

- ☐ The member's claim is missing information. We requested this information but did not receive it within 45 days of the request.
- ☐ The member received services not covered by CalOptima at the time of service.
- ☐ The member received services when not eligible for reimbursement.
- ☐ The member received services when prior authorization was required but not obtained.
- ☐ The member received services out of network for non-emergency services.
- ☐ The member received services from a non-participating Medi-Cal provider.
- ☐ The member received services that do not comply with CalOptima's utilization protocols, policies and procedures as of the date of service.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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If you have any questions, please call CalOptima Customer service at **1-714-246-8833**.
TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3
Member Notice C

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payments you made for medical care. Medi-Cal sent your request to CalOptima for review.

Your claim has been modified. You asked Medi-Cal to reimburse you $XXX. The Medi-Cal rate for your medical service is $XXX. This is the maximum amount CalOptima will pay for this service.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

If you have any questions, please call CalOptima Customer service at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Authority: Welfare and Institutions Code, Section 14019.3
Member Notice D

Conlan Letter_Member Notice D

DATE

NAME
ADDRESS
ADDRESS

Beneficiary Reimbursement Reference Number:

Dear NAME:

This letter is about the claim you filed with Medi-Cal. You asked Medi-Cal to reimburse you for payment(s) you made for medical care. Medi-Cal forwarded your request to CalOptima for review. CalOptima administers Medi-Cal for Orange County.

CalOptima has received your claim form and attachments. We will review your claim. If we need more information, we will send you a letter telling you what other information you need to send to us. If CalOptima needs more information, this may delay the processing of your claim.

After CalOptima reviews your claim, we will send you a written notice that tells you what CalOptima decided. We will mail that notice to you within 120 days after we received your claim.

If you do not agree with this decision, you have the right to file an appeal and exhaust all appeal rights with CalOptima **within 60 days from the date at the top of this letter** before filing for a State Hearing. Attached is information about how to file for a State Hearing.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how you may file an appeal and the cut-off dates to ask for an appeal. It also tells you where you can get free legal help. When filing an appeal, you are encouraged to send in any information that could help your case.

If you have any questions, please call CalOptima Customer service at **1-714-246-8833**. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

Sincerely,

Claims Administration
CalOptima

Conlan Letter_Member Notice E

Authority: Welfare and Institutions Code, Section 14019.3
Member Notice E

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 800-735-2929

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Policy:	FF.2011
Title:	~~Directed Payments~~Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20201119 PAC Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which ~~CalOptima and~~ a Health Network shall administer the Directed Payments for Qualifying Services, ~~including~~and processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A and, as applicable, Attachment B of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) ~~approved preprint~~Approved Preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

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6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services ~~and~~, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and ~~Procedure Codes~~procedure codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, a Health Network shall further ensure that the VBP measures and the ICD-10 Codes reported are appropriate for the services being provided as well as any other data requested by CalOptima.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e~~.~~., Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

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2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.
   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers ~~that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics~~ rendering Developmental Screening Services to an Eligible Member. A Developmental

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Screening Service must be provided in accordance with the American Academy of Pediatrics~~/~~ (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

a. The following Developmental Screening Services are eligible for an Add-On Payment:
   i. A routine screening when provided:

      1) On or before the first birthday~~;~~ (twelve (12) months);

      2) After the first birthday and before or on the second birthday~~;~~ (twenty-four (24) months); or

      3) After the second birthday and on or before the third birthday~~.~~ (thirty-six (36) months).

   ii. Developmental Screening Services provided when ~~medically necessary~~Medically Necessary, in addition to routine screenings~~.~~, subject to the following conditions:

      1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

      2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

   i. The tool that was used to perform the Developmental Screening Service;

   ii. That the completed screen was reviewed;

   iii. The interpretation of results;

   iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

   v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of ~~the~~this Policy conflicts with the applicable requirements of DHCS guidance, CMS-~~approved preprint~~Approved Preprint, regulations, and/or statutes, such requirements shall control.

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3. Family Planning Services: For dates of service on or after July 1, 2019, a Health Network shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

   a. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

   b. Family Planning Services are not subject to any prior authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, a Health Network shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

   a. An Add-On Payment for qualifying VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

      i. Possess an individual (Type 1) National Provider Identifier (NPI); and

      ii. Are practicing within their practice scope.

   b. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

   c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, a Health Network shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, a Health Network shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

~~3.~~5. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs ~~screening services~~Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

      ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

      iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and

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self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

~~4.~~6. Abortion Services: For dates of service on or after July 1, ~~2018~~2017, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance ~~and~~or post-payment recovery, in accordance with its contractual obligations to CalOptima.

~~5.~~7. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima~~.~~

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B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (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 the Health Network no later than one (1) year ~~after~~from the date of service.

   a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

   b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

   a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

   b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020,

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provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the ~~Add-On~~Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

c. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

d. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment ~~reports~~report(s) in accordance with Section III.D. of this Policy.

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a. ~~The~~Excluding the VBP Program, the CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

b. For the VBP Program, on a monthly basis, CalOptima's Quality Analytics Department shall provide a report to each Health Network via the secure file transfer protocol (sFTP).

i. The report will include at minimum, a list of:

1) Qualified providers that satisfy the requirements of Section III.A.4. of this Policy;

2) Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

3) Directed Payment amounts.

ii. CalOptima Quality Analytics Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to sending the report to the CalOptima Accounting Department to make a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit ~~a~~ Directed Payment adjustment report(s) for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit ~~an~~such adjustment report(s) in accordance with CalOptima's requirements and using CalOptima's proprietary format and file naming convention, as set forth in CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network

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shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; ~~or~~

b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services~~.~~; or

c. For the VBP Program, the Estimated Initial Month Payment shall be based upon data provided by CalOptima Quality Analytics Department to CalOptima Accounting Department.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

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1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or ~~Procedure Code~~procedure code, service month~~, payor~~ and year, program-specific measures, payer (*i.e.*, the Member's Health Network~~, or its delegated entity or subcontractor~~ that is financially responsible for the specified Directed Payment,), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

    a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

    b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised ~~05~~07/01/2020)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
~~G.~~H. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
~~H.~~I. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
~~I.~~J. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
~~J.~~K. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
~~K.~~L. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
~~L.~~M. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
~~M.~~N. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
~~N.~~O. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

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P. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
Q. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
R. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal
Revised	05/01/2020	FF.2011	Directed Payments	Medi-Cal
Revised	TBD	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS 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.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangements for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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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 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~~notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, ~~and Abortion~~Developmental Screening Services, and VBP Program Services; 2. Eligible Contracted Providers and non-contracted Providers that are ~~FQHCs, RHCs, and Indian Health~~Family Planning Providers for Family Planning Services ~~Memorandum of Agreement (IHS-MOA) 638 clinics~~; ~~2.~~3. Eligible Contracted Providers and non-contracted Providers for ~~Developmental Screening~~Abortion Services; and ~~3.~~ Non-contracted GEMT Providers for GEMT Services~~; and~~ 4. ~~Non-contracted Providers for Abortion Services.~~ .
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.

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Term	Definition
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as set forth in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	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.

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Term	Definition
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Medically Necessary or Medical Necessity	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. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

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Term	Definition
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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Policy:	FF.2011
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy establishes requirements pursuant to which a Health Network shall administer the Directed Payments for Qualifying Services, and processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A and, as applicable, Attachment B of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) Approved Preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

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6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, a Health Network shall further ensure that the VBP measures and the ICD-10 Codes reported are appropriate for the services being provided as well as any other data requested by CalOptima.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e., Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

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2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.
   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright

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Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

a. The following Developmental Screening Services are eligible for an Add-On Payment:
   i. A routine screening when provided:

      1) On or before the first birthday (twelve (12) months);

      2) After the first birthday and before or on the second birthday (twenty-four (24) months); or

      3) After the second birthday and on or before the third birthday (thirty-six (36) months).

   ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

      1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

      2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

   i. The tool that was used to perform the Developmental Screening Service;

   ii. That the completed screen was reviewed;

   iii. The interpretation of results;

   iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

   v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

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3. Family Planning Services: For dates of service on or after July 1, 2019, a Health Network shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

   a. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

   b. Family Planning Services are not subject to any prior authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, a Health Network shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

   a. An Add-On Payment for qualifying VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

      i. Possess an individual (Type 1) National Provider Identifier (NPI); and

      ii. Are practicing within their practice scope.

   b. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

   c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, a Health Network shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, a Health Network shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

5. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

      ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

      iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and

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self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance or post-payment recovery, in accordance with its contractual obligations to CalOptima.

7. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima

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B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (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 the Health Network no later than one (1) year from the date of service.

   a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

   b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

   a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

   b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020,

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provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

c. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

d. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment report(s) in accordance with Section III.D. of this Policy.

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a. Excluding the VBP Program, the CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

b. For the VBP Program, on a monthly basis, CalOptima's Quality Analytics Department shall provide a report to each Health Network via the secure file transfer protocol (sFTP).

i. The report will include at minimum, a list of:

1) Qualified providers that satisfy the requirements of Section III.A.4. of this Policy;

2) Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

3) Directed Payment amounts.

ii. CalOptima Quality Analytics Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to sending the report to the CalOptima Accounting Department to make a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit Directed Payment adjustment report(s) for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit such adjustment report(s) in accordance with CalOptima's requirements and using CalOptima's proprietary format and file naming convention, as set forth in CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network

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shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims;

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services; or

   c. For the VBP Program, the Estimated Initial Month Payment shall be based upon data provided by CalOptima Quality Analytics Department to CalOptima Accounting Department.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

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1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (*i.e.*, the Member's Health Network that is financially responsible for the specified Directed Payment,), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised 07/01/2020)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
H. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
I. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
J. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
K. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
M. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
N. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
O. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

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P. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
Q. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
R. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal
Revised	05/01/2020	FF.2011	Directed Payments	Medi-Cal
Revised	TBD	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS 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.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangements for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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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, 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 Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, Developmental Screening Services, and VBP Program Services; 2. Eligible Contracted Providers and non-contracted Providers that are Family Planning Providers for Family Planning Services; 3. Eligible Contracted Providers and non-contracted Providers for Abortion Services; and 4. Non-contracted GEMT Providers for GEMT Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.

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Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as set forth in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	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.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.

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Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Medically Necessary or Medical Necessity	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. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

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[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]*At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.*

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee ~~Payment[3]~~ Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

~~[3]Payment~~ [4]Payment obligations for rates of at least $29 for eligible service codes

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee ~~Payment~~[4] Payment[5]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

~~[4] Payment~~ [5] Payment obligations for rates of at least $400 and $700 for eligible service codes

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[6]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[6]*Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

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[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]*At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.*

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Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[4]Payment obligations for rates of at least $29 for eligible service codes

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[5]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[5]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[6]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[6]*Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

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The Department of Health Care Services (DHCS) is providing the measure specifications for the Value-Based Payment (VBP) Program measures. DHCS may make technical updates to VBP measure specifications as needed and appropriate to reflect recommended clinical practice, current coding standards, and/or changes in Centers for Medicare and Medicaid (CMS) Core Set measure specifications.

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Prenatal/Postpartum Care

Prenatal Pertussis ('Whooping Cough') Vaccine

Incentive payment to the provider for the administration of the pertussis vaccination to women who are pregnant

- Payment to rendering or prescribing provider for Tdap vaccine (CPT 90715) with an ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) anytime in the measurement year
- Payment may only occur once per delivery per patient
- Multiple births: Women who had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may count twice

This measure supports the Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Immunization Status measure. The measure looks at the percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Prenatal Care Visit

Incentive payment to the provider for ensuring that the woman comes in for her initial prenatal visit

- Payment to rendering provider for provision of prenatal and preventive care on a routine, outpatient basis - not intended for emergent events
- No more than one payment per pregnancy per plan
- Payment for the first visit in a plan that is for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) with a 992xx CPT code on the encounter

DHCS understands that women may change providers and plans during a pregnancy. Therefore, the first visit that occurs in a specific plan will be paid. The intent is to encourage that visit to happen quickly to begin the prenatal relationship.

This measure supports the Centers for Medicare and Medicaid (CMS) Child Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH). The Measure PPC-CH measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/Children's Health Insurance Program (CHIP).

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Postpartum Care Visits

Incentive payment for completion of recommended postpartum care visits after a woman gives birth

- Payment to rendering provider for provision of an Early Postpartum Visit (a postpartum visit on or between 1 and 21 days after delivery)
- Payment to rendering provider for provision of a Late Postpartum Visit (a postpartum visit on or between 22 and 84 days after delivery)
- Payment to the first visit in the time period (Early or Late)
- No more than one payment per time period (Early or Late)
- Postnatal visit is identified for this purpose by the use of the ICD-10 code for postpartum visit (Z39.2) on the encounter

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

Definitions

Early Postpartum Visit	A postpartum visit on or between 1 and 21 days after delivery
Late Postpartum Visit	A postpartum visit on or between 22 and 84 days after delivery

Incentive payments support the current American College of Obstetricians and Gynecologists recommendations regarding the two postpartum visits. DHCS expects that nationally utilized quality metrics will eventually align with the current clinical recommendations. The current CMS Adult Core Set Prenatal and Postpartum Care: Postpartum Care (PPC-AD) measure is expected to align with this in the future. The current Measure PPC-AD measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Postpartum Birth Control

Incentive payment to provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery

- Payment to rendering or prescribing provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery
- Payment to the first occurrence of contraception in the time period
- No more than one payment per delivery

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

The codes used to calculate this measure are available in Tables CCP-C through CCPD at:

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https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-ofcare%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip

This measure supports CMS Child and Adult Core Set Measures Contraceptive Care - Postpartum Measures (CCP-CH) (ages 15-20) and (CCP-AD) (ages 21-44) The Measure CCP measures among women who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Early Childhood

Well Child Visits in First 15 Months of Life

Separate incentive payment to a provider for each of the last three well child visits out of eight total - 6th, 7th and 8th visits. (Eight visits are recommended between birth and 15 months)

- Separate payment to each rendering provider for successfully completing each of the three well child visits at the following times:
  - 6 month visit – the first well care visit between 172 and 263 days of life
  - 9 month visit – the first well care visit between 264 and 355 days of life
  - 12 month visit – the first well care visit between 356 and 447 days of life
- Three payments per child are eligible for payment • Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439
  - ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the First 15 Months of Life (W15-CH). The Measure W15-CH measures the percentage of children who turned 15 months old during the measurement year and who had six or more wellchild visits with a primary care practitioner during their first 15 months of life.

Well Child Visits in 3rd – 6th Years of Life

Separate payment to each rendering provider for successfully completing each of the annual well child visits at age 3, 4, 5, and 6

- Payment for the first well child visit in each year age group (3, 4, 5, or 6 year olds)
- Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439

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- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH). The Measure W34-CH measures the percentage of children ages three to six who had one or more well-child visits with a primary care practitioner during measurement year.

All Childhood Vaccines for Two Year Olds

For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given on or before the second birthday

- Payment to each rendering provider for each final vaccine administered in a series to children turning age two in the measurement year:
  - Diphtheria, tetanus, pertussis (DTaP) – 4th vaccine
  - Inactivated Polio Vaccine (IPV) – 3rd vaccine
  - Hepatitis B – 3rd vaccine
  - Haemophilus Influenzae Type b (Hib) – 3rd vaccine
  - Pneumococcal conjugate – 4th vaccine
  - Rotavirus – 2nd or 3rd vaccine
  - Flu – 2nd vaccine
- A given provider may receive up to seven payments per year per patient
- A two year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series

This measure supports the CMS Child Core Set Childhood Immunization Status (CISCH). The Measure CIS-CH measures the percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Blood Lead Screening

Incentive payment to a provider for completing a blood lead screening in children up to two years of age

- Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday
- Provider can receive more than one payment

Blood lead tests will not be excluded if a child is diagnosed with lead toxicity.

This measure supports the HEDIS measure Lead Screening in Children (LSC). The LSC measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

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Dental Fluoride Varnish

Incentive payment to provider if provides oral fluoride varnish application for children 6 months through 5 years

- Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six
- Payment for the first four visits in a 12 month period

Chronic Disease Management

Controlling High Blood Pressure

Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years old being seen by the provider for their diagnosis of high blood pressure

- Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents controlled blood pressure
- A visit for controlled blood pressure must include a code for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension on the same day • Ages 18 to 85 at the time of the visit

Codes for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension are:

- Controlled Systolic:
  - CPT 3074F (systolic blood pressure less than 130) – CPT 3075F (systolic blood pressure less than 130-39)
- Controlled Diastolic:
  - CPT 3078F (diastolic blood pressure less than 80) – CPT 3079F (diastolic blood pressure less than 80-89)
- Hypertension:
  - ICD-10: I10 (essential hypertension)

This measure supports CMS Adult Core Set Controlling High Blood Pressure (CBP-AD). The measure CBP-AD measures the percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Diabetes Care

Incentive payment to provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that shows the results of the test for members 18 to 75 years of age

- Payment to each rendering provider for each event of diabetes (HbA1c) testing (laboratory or point of care testing) that shows the results for members 18 to 75 years as coded with:
  - CPT 3044F most recent HbA1c < 7.0%
  - CPT 3045F most recent HbA1c 7.0-9.0% (through September 30, 2019)
  - CPT 3051F most recent HbA1c >= 7.0% and < 8.0% (as of October 1, 2019)

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  - CPT 3052F most recent HbA1c 8.0-9.0% (as of October 1, 2019)
  - CPT 3046F most recent HbA1c > 9.0%
- No more than four payments per year.
- Dates for HbA1c results must be at least 60 days apart.
- Diabetes diagnosis is not required to allow for screening of individuals at increased risk of diabetes.

This measure supports both CMS Adult Core Set measures HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (HPC-AD) The measure HA1C-AD assesses the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test, and the measure HPC-AD measures the percentage with an HbA1c level <9.0%.

Control of Persistent Asthma

Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications

- Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based on the Asthma Value Set, in the measurement year or the year prior to the measurement year
- Each provider is paid once per year per patient
- Ages 5 to 64 at the time of the visit

The Asthma Value Set includes the following diagnosis codes:

J45.20 Mild intermittent asthma, uncomplicated
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus
J45.30 Mild persistent asthma, uncomplicated
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus J45.909 Unspecified asthma, uncomplicated
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma

This measure specification supports CMS Child and Adult Core Set measures Asthma Medication Ratio: Ages 5-18 (AMR-CH) and Ages 19-64 (AMR-AD). These measures assess the percentage of beneficiaries ages 5-64 who were identified as having

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persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater.

Tobacco Use Screening

Incentive payment to provider for tobacco use screening or counseling provided to members 12 years and older

- Payment to rendering provider for any of the following CPT codes: 99406, 99407, 4004F, or 1036F (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco.

This measure aligns with U.S. Preventive Services Task Force (USPFTF) recommendations with regards to screening/counseling for tobacco

- Adults: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
- Adolescents: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions

Adult Influenza ('Flu') Vaccine

Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older

- Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 and older at the time of the flu shot
- No more than one payment per patient per quarter for the first quarter of the year (January through March) or the last quarter of the year (October through December)
- If more than one provider gives the shot in the quarter only the first provider gets paid in that quarter

This measures supports the American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI) NQF 0041 Preventive Care and Screening: Influenza Immunization which assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization.

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Screening for Clinical Depression

Incentive payment to provider for conducting screening for clinical depression (using a standardized screening tool) for beneficiaries 12 years and older

- Payment to rendering provider for any of the following CPT codes for screening for clinical depression: G8431 or G8510 (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports CMS Core Set measure Screening for Depression and Followup Plan: Age 18 and Older (CDF-AD). The measure CDF-AD assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Management of Depression Medication

Incentive payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and newly treated with an anti-depressant medication who has remained on the anti-depressant medication for at least 12 weeks

- Payment to prescribing providers for the Effective Acute Phase Treatment for patients 18 years and older with a diagnosis of major depression 60 days before the new prescription through 60 days after
- Effective Acute Phase Treatment is at least 84 days during 12 weeks of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days)
- Payment to each prescribing provider that prescribed antidepressant medications during Effective Acute Phase Treatment period
- No more than one Effective Acute Phase Treatment per year

Definitions

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative medication history	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	At least 84 days of treatment beginning on the IPSD through 114 days after the IPSD.
Major depression diagnosis codes	ICD10: F32.0,F32.1,F32.2,F32.3,F32.4,F32.9,F33.0, F33.1,F33.2,F33.3,F33.41,F33.9

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Antidepressant medication	NCQA's Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndclicense/hedis-2019-final-ndc-lists/.

This measure supports the CMS Adult Core Set measure Antidepressant Medication Management (AMM-AD). The Measure AMM-AD Effective Acute Phase Treatment measures the percentage of beneficiaries age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication for at least 84 days (12 weeks).

Screening for Unhealthy Alcohol Use

Incentive payment to provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older

- Payment to rendering provider for any of the following CPT codes: 99408, 99409, G0396, G0397, G0442, G0443, H0049, or H0050 (equivalent payment for all codes)
- No more than one payment per provider per patient per year

This measure specification supports Quality Identifier #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. The Measure NQF 2152 measures the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.

The measures aligns with USPFTF Recommendations with regards to alcohol screening tools:

- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioralcounseling-interventions

Overarching Payment Conditions

Data to be used to calculate payments:

- Medi-Cal administrative data reported through the Managed Care Plans encounter data
- Medi-Cal administrative data reported in the Medi-Cal Eligibility Data System
- For measures involving immunizations, the expectation is that immunizations reported through the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 will be used as a supplementary data source
- For the Blood Lead Screening measure, the expectation is that blood lead test results reported through the CDPH Blood Lead Registry may be used as a supplementary data source

Providers will be identified based on:

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- National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1)
- If the rendering or ordering is not filled, then look for prescribing provider field that is an NPI for an individual (Type 1)
- If the rendering, ordering, or prescribing is not filled, then look for billing provider that is an NPI for an individual (Type 1)
- To qualify for payment, providers must be practicing within their practice scope and must have an individual (Type 1) NPI. For example, if a pharmacist (not the pharmacy) provides an immunization, then that pharmacist could receive payment.

Beneficiary inclusion criteria:

- Services for beneficiaries with Medicare Part B will be excluded
- Payments are based on Medi-Cal having the encounter data

Beneficiary exclusion criteria:

- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics, and Cost Based Reimbursement Clinics will be excluded from payment

An enhanced payment factor will be applied to the above services provided to beneficiaries with the following conditions:

- Substance Use Disorder (SUD) – CMS Core Set Measure Set: AOD Abuse and Dependence Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Serious Mental Illness (SMI) – CMS Core Set Measure Sets: Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set, and Major Depression Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Homeless ICD-10 Diagnosis code with the following values:
  - Z59.0 Homeless
  - Z59.1 Inadequate Housing

The SUD and SMI at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the measurement year. The diagnosis of homeless should be on the encounter data for the VBP eligible service.

Post utilization monitoring will be performed to ensure overuse of services is not occurring.

Technical Updates to the Specifications

Updated in May 7, 2020 Version:

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- Removed from the Diabetes measure the reference to the Hemoglobin A1c (HA1C-AD) Testing measure, which was removed from the CMS Adult Core Set in the 2020 reporting year (data collection year 2019).
- Adjusted the Diabetes measure to indicate CPT 3045F is valid through September 30, 2019 and is replaced with CPT 3051F and CPT 3052F as of October 1, 2019.
- Removed from the Tobacco Use Screening measure codes CPT G0436 and CPT G0437, which were retired September 30, 2016.
- Added to the Screening for Unhealthy Alcohol Use measure codes CPT G0442 and CPT G0443.

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Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	06/04/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

3. The Designated Provider was eligible to receive the Directed Payment.

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4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A and, as applicable, Attachment B of this Policy:

1. An Add-On Payment for Physician Services ~~and~~, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

E. CalOptima shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and ~~Procedure Codes~~procedure codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, CalOptima shall further ensure that the VBP measures and ICD-10 Codes reported are appropriate for the services being provided.

F. CalOptima shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. For CalOptima Direct, how to file a grievance and second level appeal with CalOptima. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima.

H. CalOptima Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint and/or FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, as applicable.

III. PROCEDURE

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A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers ~~that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics~~ rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics~~/~~ (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday~~;~~ (twelve (12) months);

         2) After the first birthday and before or on the second birthday~~;~~ (twenty-four (24) months); or

         3) After the second birthday and on or before the third birthday~~.~~ (thirty-six (36) months).

      ii. ~~ii.~~ Developmental Screening Services provided when ~~Medically Necessary~~Medically Necessary, in addition to routine screenings~~.~~, subject to the following conditions:

         1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

         2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

   b. Development Screening Services are not subject to any Prior Authorization requirements.

   c. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

   d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

      i. The tool that was used to perform the Developmental Screening Service;

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ii. That the completed screen was reviewed;
iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, CalOptima shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

a. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

b. Family Planning Services are not subject to any Prior Authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, CalOptima shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

a. An Add-On Payment for VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

i. Possess an individual (Type 1) National Provider Identifier (NPI); and

ii. Are practicing within their practice scope.

b. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, CalOptima shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, CalOptima shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

d. CalOptima's Quality Analytics Department shall develop a monthly report to process payments which will include, at minimum, a list of:

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i. Eligible Contracted Providers that satisfy the requirements of this Section III.A.4 of the Policy;

ii. Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

iii. Add-On Payment amount(s).

~~3.~~5. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. CalOptima shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima and/or DHCS upon request.

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~~4.~~6. Abortion Services: For dates of service on or after July 1, 2017, CalOptima shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

~~5.~~7. GEMT Services: For dates of service on or after July 1, 2018, CalOptima shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. CalOptima shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

b. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by CalOptima with specified dates of service (i.e., between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), CalOptima shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, CalOptima shall ensure subsequent Directed Payments required by this Policy are made within ninety (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 CalOptima no later than one (1) year from the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima shall ensure that Directed Payments required by this Policy are made:

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a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.
b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima shall:

1. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

2. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima to the GEMT Provider; or

iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Provider, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

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1. CalOptima shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Policy FF.2011: Directed Payments, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by DHCS, including an attestation confirming the completion of the report. Reports shall include CalOptima's Health Care Plan Code, as well as CPT, HCPCS, or ~~Procedure Code~~procedure code, service month and year, program-specific measures, payer (e.g., CalOptima or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

    a. CalOptima shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima must submit an attestation to DHCS stating that no updated information is available.

    b. If updated information is available for the quarterly report, CalOptima must submit the updated quarterly report in the appropriate file format and include an attestation that CalOptima considers the report complete.

2. CalOptima shall continue to submit encounter data for the Directed Payments as required by DHCS.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised 07/01/2020)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Medi-Cal Glossary of Terms
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
G. CalOptima Policy FF.2003: Coordination of Benefits
H. CalOptima Policy FF.2011: Directed Payments
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1116: Pediatric Preventive Services
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
M. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
N. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
P. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19

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R. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services

T. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
U. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
V. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
W. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
X. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
Y. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	TBD	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS 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.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare ~~and~~& Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.

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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 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 notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, ~~and Abortion~~Developmental Screening Services, and VBP Program Services; 2. Eligible Contracted Providers and non-contracted Providers that are ~~FQHCs, RHCs, and Indian Health~~Family Planning Providers for Family Planning Services ~~Memorandum of Agreement (IHS-MOA) 638 clinics~~; ~~2.~~3. Eligible Contracted Providers and non-contracted Providers for ~~Developmental Screening~~Abortion Services; and ~~3.~~ Non-contracted GEMT Providers for GEMT Services~~; and~~ 4. ~~Non-contracted Providers for Abortion Services.~~ .
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.

For 20201019 FAC Review Only

Term	Definition
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as specified in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	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.
Ground Emergency Medical Transport (GEMT) Services	For purposes of this Policy, specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.

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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.
Medically Necessary or Medical Necessity	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. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to CalOptima Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

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Term	Definition
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	06/04/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 2020119 FAC Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

3. The Designated Provider was eligible to receive the Directed Payment.

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4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A and, as applicable, Attachment B of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

E. CalOptima shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, CalOptima shall further ensure that the VBP measures and ICD-10 Codes reported are appropriate for the services being provided.

F. CalOptima shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. For CalOptima Direct, how to file a grievance and second level appeal with CalOptima. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima.

H. CalOptima Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint and/or FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, as applicable.

III. PROCEDURE

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A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday (twelve (12) months);

         2) After the first birthday and before or on the second birthday (twenty-four (24) months); or

         3) After the second birthday and on or before the third birthday (thirty-six (36) months).

      ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

         1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

         2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

   b. Development Screening Services are not subject to any Prior Authorization requirements.

   c. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

   d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

      i. The tool that was used to perform the Developmental Screening Service;

      ii. That the completed screen was reviewed;

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iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, CalOptima shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

a. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

b. Family Planning Services are not subject to any Prior Authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, CalOptima shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

a. An Add-On Payment for VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

i. Possess an individual (Type 1) National Provider Identifier (NPI); and

ii. Are practicing within their practice scope.

b. FQHCs, RHCs, American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, CalOptima shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, CalOptima shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

d. CalOptima's Quality Analytics Department shall develop a monthly report to process payments which will include, at minimum, a list of:

i. Eligible Contracted Providers that satisfy the requirements of this Section III.A.4 of the Policy;

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ii. Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

iii. Add-On Payment amount(s).

5. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

      ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

      iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

   b. CalOptima shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

      i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

      ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

   c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

      i. The tool that was used to perform the ACEs Screening Service;

      ii. That the completed screen was reviewed;

      iii. The interpretation of results;

      iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

      v. Any appropriate actions taken.

   d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, CalOptima shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified

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to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

7. GEMT Services: For dates of service on or after July 1, 2018, CalOptima shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. CalOptima shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

b. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by CalOptima with specified dates of service (i.e., between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), CalOptima shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, CalOptima shall ensure subsequent Directed Payments required by this Policy are made within ninety (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 CalOptima no later than one (1) year from the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

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b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima shall:

1. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

2. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima to the GEMT Provider; or

iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Provider, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

1. CalOptima shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Policy FF.2011: Directed Payments, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by

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DHCS, including an attestation confirming the completion of the report. Reports shall include CalOptima's Health Care Plan Code, as well as CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (e.g., CalOptima or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

a. CalOptima shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima must submit an attestation to DHCS stating that no updated information is available.

b. If updated information is available for the quarterly report, CalOptima must submit the updated quarterly report in the appropriate file format and include an attestation that CalOptima considers the report complete.

2. CalOptima shall continue to submit encounter data for the Directed Payments as required by DHCS.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised 07/01/2020)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Medi-Cal Glossary of Terms
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
G. CalOptima Policy FF.2003: Coordination of Benefits
H. CalOptima Policy FF.2011: Directed Payments
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1116: Pediatric Preventive Services
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
M. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
N. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
P. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-015: Proposition 56

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Physicians Directed Payments for Specified Services

T. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
U. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
V. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
W. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
X. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
Y. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	TBD	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS 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.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.

For 2020119 HAC Review Only

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, 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 Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, Developmental Screening Services, and VBP Program Services; 2. Eligible Contracted Providers and non-contracted Providers that are Family Planning Providers for Family Planning Services; 3. Eligible Contracted Providers and non-contracted Providers for Abortion Services; and 4. Non-contracted GEMT Providers for GEMT Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.

For 20201119 FAC Review Only

Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as specified in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	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.
Ground Emergency Medical Transport (GEMT) Services	For purposes of this Policy, specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
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.

For 2020 10 F&C Review ONLY

Term	Definition
Medically Necessary or Medical Necessity	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. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to CalOptima Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

For 2020 10 PAC Review Only

Term	Definition
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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For 2020119 FAC Review Only

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 2020 1119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

For 2020 1/19 FAC Review Only

[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]*At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.*

For 2020 MCFAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee ~~Payment[3]~~ Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

~~[3]Payment~~ [4]Payment obligations for rates of at least $29 for eligible service codes

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee ~~Payment[4]~~Payment[5]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

~~[4]Payment~~[5]Payment obligations for rates of at least $400 and $700 for eligible service codes

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[6]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[6]*Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 2020 1119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

For 2020 1 19 FAC Review Only

[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.

For 2020 IHP FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[4]Payment obligations for rates of at least $29 for eligible service codes

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[5]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[5]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[6]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[6]*Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

For 20201119 FAC Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

The Department of Health Care Services (DHCS) is providing the measure specifications for the Value-Based Payment (VBP) Program measures. DHCS may make technical updates to VBP measure specifications as needed and appropriate to reflect recommended clinical practice, current coding standards, and/or changes in Centers for Medicare and Medicaid (CMS) Core Set measure specifications.

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Prenatal/Postpartum Care

Prenatal Pertussis ('Whooping Cough') Vaccine

Incentive payment to the provider for the administration of the pertussis vaccination to women who are pregnant

- Payment to rendering or prescribing provider for Tdap vaccine (CPT 90715) with an ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) anytime in the measurement year
- Payment may only occur once per delivery per patient
- Multiple births: Women who had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may count twice

This measure supports the Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Immunization Status measure. The measure looks at the percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Prenatal Care Visit

Incentive payment to the provider for ensuring that the woman comes in for her initial prenatal visit

- Payment to rendering provider for provision of prenatal and preventive care on a routine, outpatient basis - not intended for emergent events
- No more than one payment per pregnancy per plan
- Payment for the first visit in a plan that is for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) with a 992xx CPT code on the encounter

DHCS understands that women may change providers and plans during a pregnancy. Therefore, the first visit that occurs in a specific plan will be paid. The intent is to encourage that visit to happen quickly to begin the prenatal relationship.

This measure supports the Centers for Medicare and Medicaid (CMS) Child Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH). The Measure PPC-CH measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/Children's Health Insurance Program (CHIP).

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Postpartum Care Visits

Incentive payment for completion of recommended postpartum care visits after a woman gives birth

- Payment to rendering provider for provision of an Early Postpartum Visit (a postpartum visit on or between 1 and 21 days after delivery)
- Payment to rendering provider for provision of a Late Postpartum Visit (a postpartum visit on or between 22 and 84 days after delivery)
- Payment to the first visit in the time period (Early or Late)
- No more than one payment per time period (Early or Late)
- Postnatal visit is identified for this purpose by the use of the ICD-10 code for postpartum visit (Z39.2) on the encounter

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

Definitions

Early Postpartum Visit	A postpartum visit on or between 1 and 21 days after delivery
Late Postpartum Visit	A postpartum visit on or between 22 and 84 days after delivery

Incentive payments support the current American College of Obstetricians and Gynecologists recommendations regarding the two postpartum visits. DHCS expects that nationally utilized quality metrics will eventually align with the current clinical recommendations. The current CMS Adult Core Set Prenatal and Postpartum Care: Postpartum Care (PPC-AD) measure is expected to align with this in the future. The current Measure PPC-AD measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Postpartum Birth Control

Incentive payment to provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery

- Payment to rendering or prescribing provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery
- Payment to the first occurrence of contraception in the time period
- No more than one payment per delivery

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

The codes used to calculate this measure are available in Tables CCP-C through CCPD at:

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https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-ofcare%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip

This measure supports CMS Child and Adult Core Set Measures Contraceptive Care - Postpartum Measures (CCP-CH) (ages 15-20) and (CCP-AD) (ages 21-44) The Measure CCP measures among women who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Early Childhood

Well Child Visits in First 15 Months of Life

Separate incentive payment to a provider for each of the last three well child visits out of eight total - 6th, 7th and 8th visits. (Eight visits are recommended between birth and 15 months)

- Separate payment to each rendering provider for successfully completing each of the three well child visits at the following times:
  - 6 month visit – the first well care visit between 172 and 263 days of life
  - 9 month visit – the first well care visit between 264 and 355 days of life
  - 12 month visit – the first well care visit between 356 and 447 days of life
- Three payments per child are eligible for payment • Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439
  - ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the First 15 Months of Life (W15-CH). The Measure W15-CH measures the percentage of children who turned 15 months old during the measurement year and who had six or more wellchild visits with a primary care practitioner during their first 15 months of life.

Well Child Visits in 3rd – 6th Years of Life

Separate payment to each rendering provider for successfully completing each of the annual well child visits at age 3, 4, 5, and 6

- Payment for the first well child visit in each year age group (3, 4, 5, or 6 year olds)
- Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439

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- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH). The Measure W34-CH measures the percentage of children ages three to six who had one or more well-child visits with a primary care practitioner during measurement year.

All Childhood Vaccines for Two Year Olds

For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given on or before the second birthday

- Payment to each rendering provider for each final vaccine administered in a series to children turning age two in the measurement year:
  - Diphtheria, tetanus, pertussis (DTaP) – 4th vaccine
  - Inactivated Polio Vaccine (IPV) – 3rd vaccine
  - Hepatitis B – 3rd vaccine
  - Haemophilus Influenzae Type b (Hib) – 3rd vaccine
  - Pneumococcal conjugate – 4th vaccine
  - Rotavirus – 2nd or 3rd vaccine
  - Flu – 2nd vaccine
- A given provider may receive up to seven payments per year per patient
- A two year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series

This measure supports the CMS Child Core Set Childhood Immunization Status (CISCH). The Measure CIS-CH measures the percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Blood Lead Screening

Incentive payment to a provider for completing a blood lead screening in children up to two years of age

- Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday
- Provider can receive more than one payment

Blood lead tests will not be excluded if a child is diagnosed with lead toxicity.

This measure supports the HEDIS measure Lead Screening in Children (LSC). The LSC measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

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Dental Fluoride Varnish

Incentive payment to provider if provides oral fluoride varnish application for children 6 months through 5 years

- Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six
- Payment for the first four visits in a 12 month period

Chronic Disease Management

Controlling High Blood Pressure

Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years old being seen by the provider for their diagnosis of high blood pressure

- Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents controlled blood pressure
- A visit for controlled blood pressure must include a code for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension on the same day • Ages 18 to 85 at the time of the visit

Codes for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension are:

- Controlled Systolic:
  - CPT 3074F (systolic blood pressure less than 130) – CPT 3075F (systolic blood pressure less than 130-39)
- Controlled Diastolic:
  - CPT 3078F (diastolic blood pressure less than 80) – CPT 3079F (diastolic blood pressure less than 80-89)
- Hypertension:
  - ICD-10: I10 (essential hypertension)

This measure supports CMS Adult Core Set Controlling High Blood Pressure (CBP-AD). The measure CBP-AD measures the percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Diabetes Care

Incentive payment to provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that shows the results of the test for members 18 to 75 years of age

- Payment to each rendering provider for each event of diabetes (HbA1c) testing (laboratory or point of care testing) that shows the results for members 18 to 75 years as coded with:
  - CPT 3044F most recent HbA1c < 7.0%
  - CPT 3045F most recent HbA1c 7.0-9.0% (through September 30, 2019)
  - CPT 3051F most recent HbA1c >= 7.0% and < 8.0% (as of October 1, 2019)

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  - CPT 3052F most recent HbA1c 8.0-9.0% (as of October 1, 2019)
  - CPT 3046F most recent HbA1c > 9.0%
- No more than four payments per year.
- Dates for HbA1c results must be at least 60 days apart.
- Diabetes diagnosis is not required to allow for screening of individuals at increased risk of diabetes.

This measure supports both CMS Adult Core Set measures HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (HPC-AD) The measure HA1C-AD assesses the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test, and the measure HPC-AD measures the percentage with an HbA1c level <9.0%.

Control of Persistent Asthma

Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications

- Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based on the Asthma Value Set, in the measurement year or the year prior to the measurement year
- Each provider is paid once per year per patient
- Ages 5 to 64 at the time of the visit

The Asthma Value Set includes the following diagnosis codes:

J45.20 Mild intermittent asthma, uncomplicated
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus
J45.30 Mild persistent asthma, uncomplicated
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus J45.909 Unspecified asthma, uncomplicated
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma

This measure specification supports CMS Child and Adult Core Set measures Asthma Medication Ratio: Ages 5-18 (AMR-CH) and Ages 19-64 (AMR-AD). These measures assess the percentage of beneficiaries ages 5-64 who were identified as having

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persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater.

Tobacco Use Screening

Incentive payment to provider for tobacco use screening or counseling provided to members 12 years and older

- Payment to rendering provider for any of the following CPT codes: 99406, 99407, 4004F, or 1036F (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco.

This measure aligns with U.S. Preventive Services Task Force (USPFTF) recommendations with regards to screening/counseling for tobacco

- Adults: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
- Adolescents: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions

Adult Influenza ('Flu') Vaccine

Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older

- Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 and older at the time of the flu shot
- No more than one payment per patient per quarter for the first quarter of the year (January through March) or the last quarter of the year (October through December)
- If more than one provider gives the shot in the quarter only the first provider gets paid in that quarter

This measures supports the American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI) NQF 0041 Preventive Care and Screening: Influenza Immunization which assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization.

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Screening for Clinical Depression

Incentive payment to provider for conducting screening for clinical depression (using a standardized screening tool) for beneficiaries 12 years and older

- Payment to rendering provider for any of the following CPT codes for screening for clinical depression: G8431 or G8510 (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports CMS Core Set measure Screening for Depression and Followup Plan: Age 18 and Older (CDF-AD). The measure CDF-AD assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Management of Depression Medication

Incentive payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and newly treated with an anti-depressant medication who has remained on the anti-depressant medication for at least 12 weeks

- Payment to prescribing providers for the Effective Acute Phase Treatment for patients 18 years and older with a diagnosis of major depression 60 days before the new prescription through 60 days after
- Effective Acute Phase Treatment is at least 84 days during 12 weeks of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days)
- Payment to each prescribing provider that prescribed antidepressant medications during Effective Acute Phase Treatment period
- No more than one Effective Acute Phase Treatment per year

Definitions

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative medication history	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	At least 84 days of treatment beginning on the IPSD through 114 days after the IPSD.
Major depression diagnosis codes	ICD10: F32.0,F32.1,F32.2,F32.3,F32.4,F32.9,F33.0, F33.1,F33.2,F33.3,F33.41,F33.9

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Antidepressant medication	NCQA's Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndclicense/hedis-2019-final-ndc-lists/.

This measure supports the CMS Adult Core Set measure Antidepressant Medication Management (AMM-AD). The Measure AMM-AD Effective Acute Phase Treatment measures the percentage of beneficiaries age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication for at least 84 days (12 weeks).

Screening for Unhealthy Alcohol Use

Incentive payment to provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older

- Payment to rendering provider for any of the following CPT codes: 99408, 99409, G0396, G0397, G0442, G0443, H0049, or H0050 (equivalent payment for all codes)
- No more than one payment per provider per patient per year

This measure specification supports Quality Identifier #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. The Measure NQF 2152 measures the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.

The measures aligns with USPFTF Recommendations with regards to alcohol screening tools:

- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioralcounseling-interventions

Overarching Payment Conditions

Data to be used to calculate payments:

- Medi-Cal administrative data reported through the Managed Care Plans encounter data
- Medi-Cal administrative data reported in the Medi-Cal Eligibility Data System
- For measures involving immunizations, the expectation is that immunizations reported through the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 will be used as a supplementary data source
- For the Blood Lead Screening measure, the expectation is that blood lead test results reported through the CDPH Blood Lead Registry may be used as a supplementary data source

Providers will be identified based on:

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- National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1)
- If the rendering or ordering is not filled, then look for prescribing provider field that is an NPI for an individual (Type 1)
- If the rendering, ordering, or prescribing is not filled, then look for billing provider that is an NPI for an individual (Type 1)
- To qualify for payment, providers must be practicing within their practice scope and must have an individual (Type 1) NPI. For example, if a pharmacist (not the pharmacy) provides an immunization, then that pharmacist could receive payment.

Beneficiary inclusion criteria:

- Services for beneficiaries with Medicare Part B will be excluded
- Payments are based on Medi-Cal having the encounter data

Beneficiary exclusion criteria:

- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics, and Cost Based Reimbursement Clinics will be excluded from payment

An enhanced payment factor will be applied to the above services provided to beneficiaries with the following conditions:

- Substance Use Disorder (SUD) – CMS Core Set Measure Set: AOD Abuse and Dependence Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Serious Mental Illness (SMI) – CMS Core Set Measure Sets: Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set, and Major Depression Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Homeless ICD-10 Diagnosis code with the following values:
  - Z59.0 Homeless
  - Z59.1 Inadequate Housing

The SUD and SMI at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the measurement year. The diagnosis of homeless should be on the encounter data for the VBP eligible service.

Post utilization monitoring will be performed to ensure overuse of services is not occurring.

Technical Updates to the Specifications

Updated in May 7, 2020 Version:

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- Removed from the Diabetes measure the reference to the Hemoglobin A1c (HA1C-AD) Testing measure, which was removed from the CMS Adult Core Set in the 2020 reporting year (data collection year 2019).
- Adjusted the Diabetes measure to indicate CPT 3045F is valid through September 30, 2019 and is replaced with CPT 3051F and CPT 3052F as of October 1, 2019.
- Removed from the Tobacco Use Screening measure codes CPT G0436 and CPT G0437, which were retired September 30, 2016.
- Added to the Screening for Unhealthy Alcohol Use measure codes CPT G0442 and CPT G0443.

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Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

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I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a Health Network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted Provider.

B. A Provider shall submit a claim for Covered Services rendered on, or after, January 1, 2010 as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the contracted Provider agreement. If the contracted Provider agreement does not specify a time frame, the contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services - Emergency medical services *do not* require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of an inpatient admission from the ER on file for the room and board charges, CalOptima or a Health Network must pay the emergency triage fee and request Medical Records;

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3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima policies to be services the Member was entitled to have furnished, or paid for, by CalOptima or a Health Network; and

7. CalOptima or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts.

D. CalOptima or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider Agreement.

2. Non-Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

b. CalOptima or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

c. If CalOptima or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

d. CalOptima or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

i. Effective January 1, 2021, CalOptima or a Health Network ~~may~~shall apply positive MIPS payment adjustments ~~either at~~, within thirty (30) calendar days of receipt of a clean claim regardless of the ~~time the payment is made during the applicable MIPS~~

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~~payment year or as a retroactive adjustment to paid claims.~~dates of service.

~~i. CalOptima or a Health Network are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.~~

E. If CalOptima or a Health Network denies payment of a Clean Claim, CalOptima or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the Member of his or her right to request an Appeal;

c. Describe the Appeals process, time frames, and other elements; and

d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program, but is covered by and payable under a Member's Medi-Cal coverage, CalOptima or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

~~H.~~I. Provider Appeal and Grievance

1. A Provider may Appeal a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

2. A Provider may file a Grievance in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

III. PROCEDURE

A. If CalOptima or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) working days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima or a Health Network receives an Invalid or Incomplete Claim, it shall notify the

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Provider no later than ten (10) working days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, CalOptima's or a Health Network notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) working days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

   a. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima or a Health Network shall send a second (2nd) letter to the contracted/Non-Contracted Provider requesting such information.

   b. If CalOptima or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a Provider Grievance, in accordance with Section II.I. of this Policy.

6. If CalOptima or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a Grievance in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima or a Health Network Reopening of Claims

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1. CalOptima or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima or a Health Network, such as:

   a. Mathematical or computational mistakes;

   b. Transposed procedure or diagnostic codes;

   c. Inaccurate data entry;

   d. Misapplication of a fee schedule;

   e. Computer errors;

   f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

   g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

   a. Failing to bill for certain items or services;

   b. Untimely filing; or

   c. Redetermination requests.

3. CalOptima or a Health Network, a Provider, or any other party to the determination decision may request CalOptima or a Health Network reopen a claim as follows:

   a. The request may be made verbally or in writing.

   b. CalOptima or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

   c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima or a Health Network shall issue a revised electronic or paper remittance advice notice.

   d. If the reopening action results in an adverse revised claim determination or decision, CalOptima or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide Appeal rights.

4. When reviewing a request to reopen a claim, CalOptima or a Health Network can consider new and material evidence if it meets the following:

   a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

   b. Does not include evidence that was or reasonably could have been, available to the decision-maker at the time the decision was made; and

   c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

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5. CalOptima or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

7. The decision of CalOptima or a Health Network to reopen a claim determination is not an initial claim determination and is therefore not subject to Appeal.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima or a Health Network shall ensure the following for written notifications:

a. Are delivered to the last known address when the determination or decision is reopened and revised;

b. State the rational and basis for the reopening and revision;

c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

d. Provide information on any appeal rights.

~~D.~~G. Record Maintenance

1. CalOptima or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NCMCP; OMB Approval 0938-0829 (Expires: 02/28/2023~~01/31/2020) H5433_UM17_3a (Rev 8/30/17)~~)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for

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Medicare Advantage

B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima PACE Program Agreement
D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy CMC.9005: Payment Appeal
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
I. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
J. CalOptima Policy MA.3103: Coordination of Benefits
K. CalOptima Policy MA.9003: Standard Appeal
L. CalOptima Policy MA.9004: Expedited Appeal
M. CalOptima Policy MA.9005: Payment Appeal
N. CalOptima Policy MA.9006: Provider Complaint Process
O. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
P. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
~~O.~~Q. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
~~P.~~R. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
S. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
~~Q.~~T. Patient Protection and Affordable Care Act, §6404
~~R.~~U. Title 31, United States Code (U.S.C.), §3902(a)
S. Title 42, Code of Federal Regulations (C.F.R.), ~~§§405.927, 405.980(a)(3),~~ 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. 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.
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.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

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Term	Definition
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Emergency Care	PACE: Covered services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Emergency Services	~~Covered Services furnished~~OneCare/OneCare Connect: Those covered inpatient and outpatient services required that are: 1. Furnished by ~~Provider~~a physician qualified to furnish ~~those health~~emergency services ~~needed~~; and ~~1.~~2. Needed to evaluate or stabilize an Emergency Medical Condition.

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Term	Definition
Grievance	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any ~~Complaint~~complaint or dispute, other than one ~~involving~~that constitutes an ~~Organization~~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 CalOptima's~~, a Health Network's,~~ or ~~a~~ Provider's operations, activities, or behavior, regardless of ~~any request for remedial action~~whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (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 Member's rights). Also called a "Complaint." 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 staff members; 4. Adequacy of center facilities; 5. Quality of the food provided; 6. Transportation services; and 7. A violation of a Participant's rights.
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.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

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Term	Definition
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 a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, ~~Health Network, Physician Medical Group,~~ or other person or institution who furnishes Covered Services.

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Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

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I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a Health Network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted Provider.

B. A Provider shall submit a claim for Covered Services rendered on, or after, January 1, 2010 as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the contracted Provider agreement. If the contracted Provider agreement does not specify a time frame, the contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services - Emergency medical services *do not* require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of an inpatient admission from the ER on file for the room and board charges, CalOptima or a Health Network must pay the emergency triage fee and request Medical Records;

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3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima policies to be services the Member was entitled to have furnished, or paid for, by CalOptima or a Health Network; and

7. CalOptima or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts.

D. CalOptima or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider Agreement.

2. Non-Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

b. CalOptima or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

c. If CalOptima or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

d. CalOptima or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

i. Effective January 1, 2021, CalOptima or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a clean claim regardless of the dates of service.

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E. If CalOptima or a Health Network denies payment of a Clean Claim, CalOptima or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

   a. The specific reasons for the payment denial;

   b. Inform the Member of his or her right to request an Appeal;

   c. Describe the Appeals process, time frames, and other elements; and

   d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program, but is covered by and payable under a Member's Medi-Cal coverage, CalOptima or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

I. Provider Appeal and Grievance

1. A Provider may Appeal a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

2. A Provider may file a Grievance in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

III. PROCEDURE

A. If CalOptima or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) working days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) working days after the date of receipt, in writing, with a request for the missing or invalid information.

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2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, CalOptima's or a Health Network notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) working days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

a. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima or a Health Network shall send a second (2nd) letter to the contracted/Non-Contracted Provider requesting such information.

b. If CalOptima or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a Provider Grievance, in accordance with Section II.I. of this Policy.

6. If CalOptima or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a Grievance in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima or a Health Network Reopening of Claims

1. CalOptima or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima or a Health Network, such as:

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a. Mathematical or computational mistakes;

b. Transposed procedure or diagnostic codes;

c. Inaccurate data entry;

d. Misapplication of a fee schedule;

e. Computer errors;

f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

a. Failing to bill for certain items or services;

b. Untimely filing; or

c. Redetermination requests.

3. CalOptima or a Health Network, a Provider, or any other party to the determination decision may request CalOptima or a Health Network reopen a claim as follows:

a. The request may be made verbally or in writing.

b. CalOptima or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima or a Health Network shall issue a revised electronic or paper remittance advice notice.

d. If the reopening action results in an adverse revised claim determination or decision, CalOptima or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide Appeal rights.

4. When reviewing a request to reopen a claim, CalOptima or a Health Network can consider new and material evidence if it meets the following:

a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

b. Does not include evidence that was or reasonably could have been, available to the decision-maker at the time the decision was made; and

c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

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6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

7. The decision of CalOptima or a Health Network to reopen a claim determination is not an initial claim determination and is therefore not subject to Appeal.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima or a Health Network shall ensure the following for written notifications:

a. Are delivered to the last known address when the determination or decision is reopened and revised;

b. State the rational and basis for the reopening and revision;

c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

d. Provide information on any appeal rights.

G. Record Maintenance

1. CalOptima or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NCMCP; OMB Approval 0938-0829 (Expires: 02/28/2023)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima PACE Program Agreement

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D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy CMC.9005: Payment Appeal
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
I. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
J. CalOptima Policy MA.3103: Coordination of Benefits
K. CalOptima Policy MA.9003: Standard Appeal
L. CalOptima Policy MA.9004: Expedited Appeal
M. CalOptima Policy MA.9005: Payment Appeal
N. CalOptima Policy MA.9006: Provider Complaint Process
O. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
P. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
Q. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
R. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
S. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
T. Patient Protection and Affordable Care Act, §6404
U. Title 31, United States Code (U.S.C.), §3902(a)
S. Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare

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Action	Date	Policy	Policy Title	Program(s)
				OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. 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.
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.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

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Term	Definition
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Emergency Care	PACE: Covered services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Emergency Services	OneCare/OneCare Connect: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: 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 CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (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 Member's rights). Also called a "Complaint." 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 staff members; 4. Adequacy of center facilities; 5. Quality of the food provided; 6. Transportation services; and 7. A violation of a Participant's rights.

For 2020 1/9 FAC Review Only

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.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
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 a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution who furnishes Covered Services.

For 2020 1/9 FAC Review Only

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Payment

Date:

Member number:

Claim number:

Name: **<Beneficiary's full name>**
<Beneficiary's street address>
<Beneficiary's city, state, zip>

Your request was *denied*

We've *denied* the *payment of medical services/items or Part B drug or Medicaid drug* listed below requested by you or your doctor [*provider]*:

Why did we deny your request?

We *denied* the *payment of medical services/items or Part B drug or Medicaid drug* listed above because

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You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare (HMO SNP) to review our decision by asking us for an appeal**.** [If the action taken involves Medicaid benefits insert the following: Plan level appeal's process must be exhausted prior to requesting a State Hearing.]

Plan Appeal: Ask OneCare for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with OneCare" for information on how to ask for a plan level appeal.

> ***How to keep your services while we review your case:*** *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your appeal, you may have to pay for these services.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: **1-877-412-2734** to learn how to name your representative. TTY users call <**1-800-735-2929**>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Important Information About Your Appeal Rights

There are 2 kinds of appeals with OneCare

Standard Appeal – We'll give you a written decision on a standard appeal within ***30 days*** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a medical service/item or Part B drug you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a *medical service/item or Part B drug* you've already received.

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with OneCare

Step 1: You, your representative, or your doctor [*provider*] must ask us for an appeal. Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the *medical service/item or Part B drug or Medicaid drug*. Call your doctor if you need this information.

If you're asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.
We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal. You can also call us .

For a Standard Appeal:

Mailing Address: OneCare
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868
Phone: 1-877-412-2734 TTY Users Call: <1-800-735-2929>
Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: 1-877-412-2734 TTY Users Call: <1-800-735-2929>
Fax: 1-714-246-8562

What happens next?

If you ask for an appeal and we continue to deny your request for *payment of* a *medical service/item or Part B drug or Medicaid drug*, we'll automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

How to ask for a Medicaid State Fair Hearing

If OneCare denies your appeal request, you can take the steps listed below to request a State Fair Hearing.

Step 1: *You or your representative must ask for a State Fair Hearing (in writing) within 120 days of the date of the notice that denies your appeal request. You have up to <180> days if you have a good reason for your request being late.*

Your {written} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: *Send your request to:*
California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Phone: 1-800-952-5253 Fax: 1-916-651-5210 or 1-916-651-2789

[A copy of this notice has been sent to:]

Get help & more information

- OneCare Customer Service: Toll Free: 1-877-412-2734, TTY users call: <1-800-735-2929> 24 hours, 7 days a week or www.caloptima.org/onecare.
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.
- Medi-Cal Managed Care Ombudsman Office: 1-888-452-8609
- Office on Aging, OC Community Services: 1-800-510-2020

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-412-2734** (TTY: <**1-800-735-2929**>).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-412-2734** (TTY: <**1-800-735-2929**>).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-412-2734** (TTY: <**1-800-735-2929**>).

{Enclosures: Notice of Non Discrimination: H5433_20MM012_C}

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." You can also see Chapter 9 of the Member Handbook for information about how to make an appeal.

Notice of Denial of Payment

Date:

Member number:
Claim number:

Name:

Your request was denied

We've denied the payment of medical services/items listed below requested by you or your doctor [*provider*]:

[service] [service dates]

Why did we deny your request?

We denied the payment of medical services/items listed above because:

[Remarks]

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) to review our decision by asking us for a Level 1 Appeal (sometimes called an "internal appeal" or "plan appeal").

Level 1 Appeal with OneCare Connect: Ask OneCare Connect for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for a Level 1 Appeal with OneCare Connect" for information on how to ask for a plan level appeal.

How to keep your services while we review your case: *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-855-705-8823 to learn how to name your representative. TDD/TTY users call 1-800-735-2929. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

There are 2 kinds of Level 1 appeals with OneCare Connect

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**.

Fast (Expedited) Appeal *– We'll give you a decision on a fast appeal as expeditiously as your condition requires, and always within* ***72 hours*** *after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a decision on a standard appeal.*

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. *If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.*

How to ask for a Level 1 Appeal with OneCare Connect

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal: Address: OneCare Connect
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

Phone: 1-855-705-8823 TTY Users Call: 1-800-735-2929
Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

For a Fast (Expedited) Appeal: Phone: 1-855-705-8823 TTY Users Call: 1-800-735-2929
Fax: 1-714-246-8562}

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for {*payment of*} a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree.

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of this notice. Fill out the "Form to File a State Hearing" that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TDD: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

A copy of this notice has been sent to: [*insert name*]

Get help & more information

- Call **OneCare Connect** at 1-855-705-8823, 24 hours, 7 days a week. TDD/TTY users call 1-800-735-2929. You can also visit our website at www.caloptima.org/onecareconnect.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-888-HMO-9050.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- If this notice is about your In-Home Supportive Services (IHSS) benefits, call your **local county social services office** for help. The phone number is 1-714-825-3000 and 1-800-281-9799.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also see **Chapter 9 of the Member Handbook** for information about how to make an appeal.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. You can get this information for free in other languages. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).
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 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-855-705-8823 (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-855-705-8823 (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝
1-800-735-2929):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

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ます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم
(**1-800-735-2929**: TTY الهاتف النصي/خط الاتصال لضعاف السمع) **1-855-705-8823**

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau
1-855-705-8823 (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-855-705-8823 (TTY: 1-800-735-2929)**.

CalOptima PACE
13300 Garden Grove Blvd
Garden Grove, CA 92843
(714) 468-1100
TDD/TTY: (714) 468-1063

{Date}

{Participant's Name or Representative}
{C/o Participant's Name}
{Address}

RE: Notice of Action (NOA) for Service or Payment Request

Dear Mr/s {Name}:

Your request of [insert date] for [insert brief description of requested service or payment for service]

Has been: __**Denied** __**Deferred** __**Modified** for the reason(s) indicated below:

- ❑ Is not medically necessary
- ❑ Requested services will not improve or contribute to sustaining your health
- ❑ An alternative service is provided to meet your care needs
- ❑ Did not meet authorization criteria
- ❑ Is not a benefit of the PACE Program
- ❑ Requires additional information or consult
- ❑ Requested service has potentially negative health and safety issues
- ❑ Other (please describe):_____

This decision was based on the following criteria or clinical guidelines:
Claim ID can be included here with your language about the decision.

If you do not agree with the action above, you have the right to appeal the decision. Please see the attached *"Information for Participants about the Appeals Process"* for your right to request further action. You may call your Social Worker or our Quality Assurance Department at (714) 468-1100 who will explain these processes to you. For the hearing impaired (TTY/TDD), please call (714) 468-1063.

Sincerely,

[First Initial and last name of Examiner
Claims Administration

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INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

All of us at **CalOptima PACE** share responsibility for your care and your satisfaction with the services you receive. Our appeals process is designed to enable you and/or your representative the opportunity to respond to a decision made by the Interdisciplinary Team regarding your request for a service or payment of a service. At any time you wish to file an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because an appeal has been filed. **CalOptima PACE** will continue to provide you with all the required services during the appeals process. The confidentiality of your appeal will be maintained at all times throughout and after the appeals process and information pertaining to your appeal will only be released to authorized individuals.

When **CalOptima PACE** decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing— is called an "**appeal**." You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process at enrollment (see your Member Enrollment Agreement Terms and Conditions) and annually after that. You will also receive this information and necessary appeals forms whenever **CalOptima PACE** denies, defers or modifies a request for a service or request for payment.

Definitions:
An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service, including denials, reductions or termination of services.

A **representative** is the person who is acting on your behalf or assisting you, and may include, but is not limited to, a family member, a friend, a PACE employee or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If you

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request and expedited appeal, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

*Note: For **CalOptima PACE** participants enrolled in Medi-Cal – **CalOptima PACE** will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.*

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and **CalOptima PACE** denies, defers or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.
2. You can make your appeal either verbally(in person or by telephone) or in writing; ask any PACE Program staff of the center you attend to help you start the process. CalOptima PACE will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review. To submit relevant facts and/or evidence in writing, please send to the address listed below. Otherwise you or your representative may submit this information in person. If more information is needed, you will be contacted by **the Quality Assurance Department** who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our **Quality Assurance Department** at **714-468-1100 or our toll-free number at (855) 785-2584** to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call **(714) 468-1063**.
4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   Quality Assurance Department
   CalOptima PACE
   13300 Garden Grove Blvd
   Garden Grove, CA 92843

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For and expedited appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.

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6. The reconsideration of **CalOptima PACE** decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon **CalOptima PACE** completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, **CalOptima PACE** will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on your Appeal:
If we decide fully in your favor on a **standard appeal** for a request for ***service***, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide in your favor** on a request for ***payment***, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights,** below). We also are required to notify you as soon as we make a decision and also to notify the federal Center for Medicare and Medicaid Services and the Department of Health Care Services. We will inform you in writing of your **external** appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which external program to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

If we decide fully in your favor on an **expedited appeal** we are required to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights**). We are required to notify you as soon as we make a decision and also to notify the Center for Medicare and Medicaid Services and the Department of Health Care Services. We let you know in writing of your **external appeal** rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

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The **Medicare program** contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if **CalOptima PACE** wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in **Medicare Medi-Cal program or both,** we will help you choose which external appeal process you should follow. We also will send your appeal on to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal options are described below.

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Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: (800)-952-5253
Facsimile: (916) 651-5210 or (916) 651-2789
TDD: (800)-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the *Notice of Action (NOA) for Service or Payment Request* from **CalOptima PACE**.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend, or an attorney. You may also be able to get free legal help. Attached is a list of Legal Services offices in **Orange County**, if you would like legal services assistance.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, **CalOptima PACE** will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is **not** in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeals, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medicare only,** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal file to the current contracted Medicare appeals entity to impartially review the appeal. The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor. The current Medicare appeals entity is:

Maximus Federal Services
Medicare Managed Care & PACE
Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14524-1302
Telephone: (585) 348-3300
Facsimile: (585) 425-5292

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: April 20, 2020

ALL PLAN LETTER 20-010
SUPERSEDES POLICY LETTER 08-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: COST AVOIDANCE AND POST-PAYMENT RECOVERY FOR OTHER HEALTH COVERAGE

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification and guidance to Medi-Cal managed care health plans (MCPs) with respect to the requirements for cost avoidance and post-payment recovery when an MCP member has other health coverage (OHC). These requirements also include instructions on the use of the Department of Health Care Services' (DHCS) Medi-Cal eligibility record to process OHC claims and guidelines on reporting to DHCS if the MCP becomes aware of OHC that is not listed on the eligibility record.

BACKGROUND:
State law requires Medi-Cal to be the payer of last resort for services in which there is a responsible third party.[1] Medi-Cal members with OHC must utilize their OHC for covered services prior to accessing their Medi-Cal benefits.[2] Cost avoidance is the practice of requiring providers to bill liable third parties prior to seeking payment from the Medi-Cal program.

Pursuant to federal law, states must take all reasonable measures to determine the legal liability of third parties and seek reimbursement for covered services for which the third party is liable.[3] This requirement is referred to as post-payment recovery and

[1] Welfare and Institutions Code (WIC) section 14124.90 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14124.90
[2] Title 22 of the California Code of Regulations (CCR), section 50763(a)(3). CCRs are searchable at: https://govt.westlaw.com/calregs/Document/IB1B147B0D4B811DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
[3] Social Security Act section 1902(a)(25) is available at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

extends to MCPs that administer health care on behalf of DHCS. MCPs that have accepted a claim from a provider for which there was OHC present on the member's Medi-Cal eligibility record at the time of service must engage in post-payment recovery for the reasonable value of the services from the liable third party. Additional information detailing private health care coverage requirements are further defined in state law[4] and the MCP contracts.[5]

POLICY:

1. Using the Medi-Cal Eligibility Record for Processing OHC Claims

    - MCPs should rely on the Medi-Cal eligibility record for cost avoidance and post-payment recovery purposes.
    - MCPs that become aware of OHC from sources other than the Medi-Cal eligibility record may use this OHC information, but must report the OHC to DHCS by submitting an OHC Removal or Addition form[6] or through batch updates[7].

2. OHC Reporting Requirements and Delivery Options

    - MCPs must report new OHC information not found on the Medi-Cal eligibility record or OHC information that is different from what is found on the Medi-Cal eligibility record to DHCS within 10 calendar days of discovery. This requirement ensures timely receipt of all new or updated OHC information so that the Third Party Liability and Recovery Division (TPLRD) can verify the information and update the member's Medi-Cal eligibility record, if valid. MCPs must report this OHC information to DHCS by either:

        - Completing and submitting an OHC Removal or Addition form; or
        - Reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. MCPs

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[4] WIC section 10022 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=10022.&lawCode=WIC

[5] The MCP boilerplate contract is available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

[6] The OHC Removal and Addition forms are available at: https://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx

[7] Batch processing (multiple additions/removals at a time) is done via weekly submission of an HI-36 Excel spreadsheet. Contact your MCP contract manager for the HI-36 template and instructions on how to complete it.

can contact their Managed Care Operations Division (MCOD) Contract Manager for more information regarding this process.

- Beginning January 1, 2021, MCPs must include OHC information in their notification to the provider when a claim is denied due to the presence of OHC. OHC information includes, but is not limited to, the name of the OHC provider, the policy number, and contact or billing information. OHC information known to DHCS is provided to all MCPs on a monthly basis. Prior to January 1, 2021, MCPs may direct providers to access the necessary member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295, or the Medi-Cal Online Eligibility Portal.[8] Information pertaining to OHC carriers can be found in the Health and Human Services Open Data Portal.[9]

3. Cost Avoidance

- Prior to delivering services to members, MCPs must ensure providers review the Medi-Cal eligibility record for the presence of OHC. If the member has active OHC, MCPs must ensure providers compare the OHC code (Appendix A) to the requested service. If the requested service is covered by the OHC, MCPs must ensure providers instruct the member to seek the service from the OHC carrier.
- Regardless of the presence of OHC, MCPs must ensure providers do not refuse a covered Medi-Cal service to a Medi-Cal member.[10]
- Effective February 9, 2018, in accordance with federal law, prenatal care is subject to cost avoidance.[11] In cases where prenatal service billing is bundled with claims for other services, MCPs must ensure providers cost-avoid the entire claim.
- MCPs must not process claims for a member whose Medi-Cal eligibility record indicates OHC, other than a code of A or N, unless the provider presents proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly. For more information regarding direct bill services, please refer to the list of direct bill Current Procedural

[8] The Medi-Cal Online Eligibility Portal is available at: https://www.medi-cal.ca.gov/Eligibility/Login.asp
[9] The Health and Human Services Open Data Portal is available at: https://data.chhs.ca.gov/dataset/aevs-carrier-codes-for-other-health-coverage
[10] Title 42 U.S. Code section 1396a(a)(25)(D) is available at: https://www.law.cornell.edu/uscode/text/42/1396a
[11] Section 53102 of the Bipartisan Budget Act of 2018 is available at: https://www.congress.gov/bill/115th-congress/house-bill/1892/text

Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes.[12]
- Acceptable forms of proof that all sources of payment have been exhausted include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation that the provider has billed the OHC and received no response for 90 days.

4. Post-Payment Recovery

- MCPs must engage in post-payment recovery if OHC is discovered retroactively or the member had an OHC indicator code of A on their Medi-Cal eligibility record at the time of service.
- For the purpose of post-payment recovery, the reasonable value of the services is the average payment the MCP pays for similar services in the particular service area, but in no event less than the Medi-Cal fee-for-service payment rate for the services rendered.
- MCPs that initiate and complete post-payment recovery within 12 months from the date of payment of a service are entitled to retain all monies recovered.
- DHCS' TPLRD will conduct post-payment recoveries and/or leverage its recovery contractor to initiate post-payment recovery beginning the 13th month following the date of payment of a service. TPLRD's recovery contractor assists with the identification and recovery of paid Medi-Cal claims for which there is liable third party. Monies recovered by TPLRD or its recovery contractor starting the 13th month after the date of payment of a service will be retained by DHCS.
- Beginning June 1, 2020, MCPs are required to submit detailed information regarding their recoveries to DHCS on a monthly report utilizing DHCS' Secure File Transfer Protocol no later than the 15th of each month. (See Appendix B for the specifics regarding the file format, required data elements, and other submission requirements).
- On a monthly basis, MCPs must report and return all recovered monies that are 13 months or older from the date of payment of a service to DHCS utilizing the monthly report (Appendix B).
- MCPs must remit warrants, payable to DHCS, for all recovered monies that are 13 months or older from the date of payment of a service to the following address:

Bank of America
P.O. Box 742635
Los Angeles, CA 90074-2635

[12] The full list of direct bill CPT and HCPCS codes is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/othhlthcpt_m00o00a02a05.doc

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

DATE January 31, 2007

MMCD All Plan Letter 07002

TO: County Organized Health Systems
Geographic Managed Care Plans
Two-Plan Model Plans

SUBJECT: *Conlan v. Bontá; Conlan v. Shewry*: Court Ordered Medi-Cal Beneficiary Reimbursement Process

Purpose

This letter provides specific instruction to County Organized Health Systems (COHS), Geographic Managed Care (GMC), and Two-Plan Model contractors and clarifies their obligations pursuant to the order(s) issued by the Superior Court, County of San Francisco in the above-referenced matters.

The California Department of Health Services (CDHS) has been ordered by the Superior Court to implement a process enabling Medi-Cal beneficiaries to obtain reimbursement of paid out-of-pocket expenses for Medi-Cal covered services received during specific periods of a beneficiary's Medi-Cal eligibility. These periods include 1) the retroactive eligibility period (up to 3 months prior to the month of application to the Medi-Cal Program); 2) the evaluation period (from the time of application to the Medi-Cal Program until eligibility is established), and 3) the post-approval period (the time period after eligibility is established).

Background

Please see the attached enclosure A, CDHS Revised Plan for Beneficiary Reimbursement, regarding the *Conlan v. Bontá; Conlan v. Shewry* court ordered Medi-Cal beneficiary reimbursement process.

Implementation

CDHS is proceeding with timely implementation of the *Conlan* court decisions and orders pursuant to the court-approved Plan.[1]

Medi-Cal providers will be sent additional and periodic bulletins to notify them of this reimbursement process and to remind them of their responsibilities to promptly reimburse beneficiaries who may have paid out-of-pocket expenses for Medi-Cal covered services. Provider bulletins will also remind providers that, for Medi-Cal managed care beneficiaries, providers must verify eligibility and seek prior authorization from the Medi-Cal managed care plan before rendering services that are non-emergency. Providers risk non-payment of claims for services if they are not a member of the provider network of the managed care plan in which the beneficiary is enrolled.

CDHS has begun mailing the Beneficiary Notice to the address of record of all current beneficiaries, as well as those individuals who were eligible at any time since June 27, 1997. The Beneficiary Notice will be sent to an estimated 11 million households. A copy of the notice is attached to the Revised Plan. The Beneficiary Notice will be printed in English and Spanish and will be accompanied by a separate enclosure entitled "REQUEST FOR NOTICE IN OTHER LANGUAGES" printed in nine additional languages spoken by the largest number of non-English speaking beneficiaries in California. Telephone operators dedicated to the reimbursement process will be available to assist beneficiaries in translating their notice from English/Spanish to the nine additional languages. It will take several weeks to complete the mailing of all Beneficiary Notices to the estimated 11 million Medi-Cal households.

The Beneficiary Notice will instruct beneficiaries to contact CDHS' Beneficiary Service Center located at Electronic Data Systems (EDS), which will be dedicated specifically to the beneficiary reimbursement process. At the time of contact, the beneficiary will be directed to the appropriate staff (medical, dental, etc.) and will receive information on what is required in order to properly submit a complete claim and for the involved department or program to approve claims for reimbursement. CDHS has developed a standardized claim form with directions on how to complete the form that can be mailed to the beneficiary at the time of initial contact and upon request to:

[1] Attached as Exhibits A and B: CDHS Revised Plan for Beneficiary Reimbursement; November 17, 2006, Superior Court order, approving same.

Beneficiary Service Center
P.O. Box 138008, Sacramento, CA 95813-8008
(916) 403-2007 or for TDD service (916) 635-6491

As a first step, CDHS will mail a claim packet to the beneficiary and the beneficiary will be directed to mail the completed claim packet to the Beneficiary Service Center, which includes:

- The Beneficiary Reimbursement Claim Form with beneficiary information;
- A completed PAYEE DATA RECORD Form (STD 204);
- A summary itemizing the covered expense(s) for which the beneficiary paid including proof of payment that shows receipt and payment of a service(s). In some cases a declaration might supplement other documentary evidence;
- A copy of his/her Medi-Cal Beneficiary Identification Card (BIC);
- The dates of service(s);
- The provider'(s) name(s) with address(es) and phone number(s) if known; and
- For those Medi-Cal services that would have required Medi-Cal authorization, documentation from the medical or dental provider that shows medical necessity for the service.

Impact to Managed Care Plans

COHS plans are capitated for Medi-Cal covered services, with the exception of those services carved-out of the contract, for the three reimbursement periods covered by the court orders. GMC and Two-Plan Model plans are capitated for Medi-Cal covered services, with the exception of those services carved-out of the contract, for the post-approval period. Therefore, a process to comply with the court-ordered reimbursement to Medi-Cal beneficiaries of paid out-of-pocket expenses for covered services will be the responsibility of the managed care plans. This applies to all beneficiaries who are/were enrolled in the plans during any of the three time periods identified that are applicable to the plan.

Claims Process

Completed claims for reimbursement will need to be adjudicated within 120 days of receipt of the beneficiary's completed claim for Medi-Cal covered expenses incurred and paid during the three time periods identified. In addition, when it is appropriate and Medi-Cal providers cooperate or funds are available from a Medi-Cal provider for recoupment, beneficiary reimbursement will be for the beneficiary's full payment of out-

of-pocket expenses. This includes amounts above the Medi-Cal rate for Medi-Cal covered services. However, if recoupment is not appropriate, then the plans will reimburse the beneficiary directly for the valid claim up to the amount paid but not to exceed the Fee-For-Service rate established under the Medi-Cal program.

Upon receipt of the beneficiary's claim by the Beneficiary Service Center, EDS will review the claim to determine if the claim is complete and meets certain criteria in order to qualify for reimbursement. Please see the attached Claim Process flow chart which outlines the claim process and lists the criteria for processing beneficiary claims. EDS will review the claim for the following criteria:

- The beneficiary was eligible for Medi-Cal at the time the service(s) was(were) provided;
  The claimed service(s) was(were) provided on or after June 27, 1997;
  The service(s) provided was(were) a Medi-Cal covered service – i.e. a Medi-Cal benefit at the time the service(s) was(were) rendered;
- The beneficiary was eligible to receive the service(s) at the time the service(s) was(were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits;
- The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.) with an itemized list of services covered by the payment, and to whom the payment was made;
  The beneficiary has submitted a completed STD 204 form;
  Claims for the evaluation period for dates of service on or after February 2, 2006, or for the post approval period were rendered by a Medi-Cal provider at the time the service(s) was provided, and
- The claim was submitted timely. Submission timelines for a timely claim are:

    1. For services received June 27, 1997 through November 16, 2006, claims must be submitted by November 16, 2007, or within 90 days after issuance of the Medi-Cal card, whichever is longer.
    2. For services received on or after November 16, 2006, claims must be submitted within one year of receipt of services or within 90 days after issuance of the Medi-Cal card, whichever is longer.

Within 15 days of receipt of the beneficiary claim, EDS will redistribute the completed claim to the managed care plan for adjudication when the claim, depending on the claim and service type, involves services covered by the managed care plan. The claim will

be sent with a Beneficiary Reimbursement Claim Referral. A copy of the referral is attached. The adjudication timeline of 120 days will begin anew from the date the managed care plan receives the completed claim from EDS. Managed Care plans will be required to send the referral form back to EDS upon adjudication of the claim.

State Hearings – New Procedures

If all or part of the beneficiary's claim is denied, managed care plans must send the beneficiary a Notice of Action (NOA) explaining what was denied and why. The NOA will provide information on how the beneficiary may file for a State Hearing. The beneficiary has 90 days from the date of the NOA to request a State Hearing.

The current State Hearing process for beneficiaries resolves disputes involving any adverse actions related to Medi-Cal eligibility or benefits. The current process is not a remedy for Medi-Cal providers to resolve other Medi-Cal payment or funding issues. However, for beneficiary reimbursement claims, the option to file a State Hearing is extended to the Medi-Cal providers, who will be allowed to provide evidence that the proposed reimbursement and recoupment is not correct. Please see the attached Revised Plan for Beneficiary Reimbursement for the detailed description of the State Hearing process outlined in the heading entitled: "G. State Hearings – New Procedures."

Should you have any questions or require additional information regarding the content of this letter, please contact your Contract Manager.

Sincerely,

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Attachments

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California Department of Health Services' Revised Plan for Beneficiary Reimbursement *Conlan v. Bontá; Conlan v. Shewry*

A. Procedural History/Background

Petitioners initiated the lawsuit entitled *Conlan v. Bontá* in June 1997. Following a ruling where the trial court denied the petition for writ in its entirety, the Court of Appeal reversed the trial court's decision in *Conlan v. Bontá* (2002) 102 Cal.App.4th 745 (*Conlan I*). In *Conlan I*, the court held that under 42 U.S.C. section 1396a(a)(10)(B) (the "comparability provision") the California Department of Health Services (Department) was required to implement a process by which Medi-Cal beneficiaries may obtain prompt reimbursement for covered services for which they paid during the three months prior to applying for Medi-Cal coverage (the "retroactivity period").

Following the issuance of *Conlan I*, the Department submitted a proposed Compliance Plan (Plan) to the trial court. Petitioners objected to several of the Plan's key provisions. The trial court found for the petitioners on all issues and concluded that the provisions were invalid. The trial court refused to approve the Department's Plan without modification to the Plan's disputed provisions. The Department appealed from that order.

On August 15, 2005, the California Court of Appeal issued its decision in the case of *Conlan v. Shewry* (2005) 131 Cal.App.4th 1354 (*Conlan II*).

In *Conlan II*, the Court of Appeal addressed five key issues relevant to the Plan's implementation. The court dismissed the Department's position that the trial court's ruling was (among other things) in conflict with California law (see Welfare and Institutions Code section 14019.3), in conflict with specific instructions from the Centers for Medicare and Medicaid Services (CMS) regarding this case (November 17, 2003 letter from CMS), and an invitation to fraud and abuse of the Medi-Cal Program. Ultimately, the court held that the Department is required to:

(1) Send notice of the new monetary reimbursement process available to all current and former Medi-Cal beneficiaries who may have claims arising on or after June 27, 1997;

(2) Provide monetary reimbursement to any individual who has a valid claim for reimbursement arising on or after June 27, 1997;

(3) Provide reimbursement for valid claims arising from the date an application for Medi-Cal eligibility is submitted to the date that the application is granted (the "evaluation period");

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(4) Provide reimbursement for services rendered by non-Medi-Cal providers if the services were provided during the retroactivity period (the Department is not required to provide reimbursement for services rendered by non-Medi-Cal providers during the evaluation period); and

(5) For valid claims, reimburse the beneficiary the amount paid, not to exceed the rate established for that service under the Medi-Cal program.

Following the issuance of *Conlan II*, the Department again submitted a proposed Plan to the trial court. In response, petitioners objected to six of the Plan's key provisions.

On February 8, 2006, the trial court found for the petitioners on four of the six issues presented, including three issues to which the Department had previously stipulated to resolve as demanded by the petitioners. Most notably, the court found that Welfare and Institutions Code, section 14019.3(g), required the Department to implement an enforcement action in order to "aggressively encourage" providers to cooperate in reimbursing beneficiary claims for reimbursement.[1] To comply with this order, the Department proposes in this Revised Plan for Beneficiary Reimbursement (Revised Plan) for court approval of the enforcement action entitled "Recoupment" by which the Department will permanently divert expected payments from a Medi-Cal provider in order to reimburse the beneficiary's valid claim.

The trial court also found that the issue regarding reimbursement of post approval expenses was not ripe for decision. The court stated it would decide "whether and the extent to which post-eligible reimbursement shall be made to beneficiaries" at a future hearing following a noticed motion and full briefing.

At the further hearing held on May 4, 2006, the trial court found for the petitioners regarding reimbursement of post approval expenses. The court directed the Department to expand the scope of post approval reimbursement, specifically invalidating a portion of Welfare and Institutions Code, section 14019.3(a)(1) that limits post approval claims for reimbursement to excess co-payments. The court issued its written order on May 18, 2006.

B. Policies/Steps Implemented

[1] "The Court hereby directs the Department to develop a more proactive provider reimbursement scheme, one that aggressively encourages voluntary provider compliance. That scheme shall set forth the specific steps the Department will take to 'ensure' voluntary compliance (W&I Code section 14019.3(h)), as well as the enforcement action the Department will follow if its voluntary compliance efforts are not successful (W&I Code section 14019.3(g)). To put the Court's expectations more directly, albeit in a somewhat colloquial manner: 'Let's see some teeth here.'" (Trial court's order, February 8, 2006: page 4, lines 11-18.)

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As a result of the trial court's February 8 and May 18, 2006 orders, the Department initiated and/or completed the following steps:

Identified and developed a process for taking action to recoup beneficiary out-of-pocket payments made to Medi-Cal providers after which a Medi-Cal provider can submit a claim to Medi-Cal for reimbursement at the Medi-Cal rate for the Medi-Cal covered service provided. (Addresses the February 8, 2006 trial court order, Issue 1

Established a new State Hearing procedure expanding the current Department of Social Services' (DSS) State Hearing process to specifically address Medi-Cal provider appeals from proposed recoupment actions. This new procedure will include Medi-Cal providers in the State Hearing when they object to a proposed recoupment by the Department on behalf of the claiming beneficiary. To accomplish this expanded procedure, the Department:

- Met with DSS weekly to identify changes to the current process,
- Developed procedures specifying steps to be taken in processing State Hearing requests,
- Reviewed current legal authority for the State Hearing process,
- Identified necessary changes to legal authority in order to implement the new State Hearing procedure. (Addresses the February 8, 2006 trial court order, Issue 1.)

Developed a notice of action (NOA) that includes a State Hearing request form for beneficiary and Medi-Cal provider requests for a State Hearing involving reimbursement process requests. (Addresses the February 8, 2006 trial court order, Issue 1.)

Expanded the Plan and Beneficiary Notice to reflect inclusion of beneficiary reimbursement for excess share of cost payments and other Medi-Cal covered services for which the beneficiary paid after Medi-Cal eligibility was determined. (Addresses the February 8, 2006 trial court order, Issue 2; and the May 18, 2006 trial court order.)

Directed DSS to send a copy of all beneficiary reimbursement State Hearing decisions to the Department. The Department will process with the decision without further action from the beneficiary. (Addresses the February 8, 2006 trial court order, Issue 3.)

Revised the Plan to reflect the 90-day timeframe for filing claims after the beneficiary is issued their Medi-Cal card. (Addresses the February 8, 2006 trial court order, Issue 4.)

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Developed an enclosure in nine additional languages to include with the Beneficiary Notice. The enclosure advises beneficiaries to call the Beneficiary Service Center telephone number if they need the notice translated in their language. (Addresses the February 8, 2006 trial court order, Issue 5.)

Developed a Beneficiary Reimbursement Claim Form for submission by a beneficiary requesting reimbursement of out-of-pocket payments for Medi-Cal covered services.

Updated the Medi-Cal beneficiary information booklet and application forms reminding Medi-Cal applicants that they need to utilize Medi-Cal providers when they receive Medi-Cal covered services in order to be reimbursed by Medi-Cal.

Coordinated meetings with other State departments and agencies regarding implementation and expectations regarding the new reimbursement process.

Revised reimbursement process notification template letters to be used during the claims adjudication process.

C. Implementation

This Plan will be implemented to the extent that Federal Financial Participation funding is available.

The Department will adjudicate completed claims for reimbursement (usually within approximately 120 days of receipt of the beneficiary's completed claim) of Medi-Cal covered services expenses incurred and paid during the retroactive period (up to 3 months prior to the time of application), during the evaluation period (from the time of application to the Medi-Cal program until the issuance of the beneficiary's Medi-Cal card), and in the post-approval period (the time period after issuance of the beneficiary's Medi-Cal card). In addition, when it is appropriate and Medi-Cal providers cooperate or funds are available from a Medi-Cal provider for recoupment,[2] beneficiary reimbursement will be for the beneficiary's full payment of out-of-pocket expenses. This includes amounts above the Medi-Cal rate for Medi-Cal covered services.

With court approval of this Revised Plan, the method of reimbursement will include: "cooperative" payments by providers; "recoupment" actions against uncooperative

[2] Whether the recoupment process is appropriate will be determined by the department or program reviewing the claim for final adjudication and/or payment. If recoupment is not appropriate, then the involved department will reimburse the beneficiary directly for the valid claim at the amount paid, not to exceed the rate established for the service under the Medi-Cal program.

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Medi-Cal providers, as more fully set forth below; and, when necessary, direct reimbursement to the beneficiary from the Department up to the current Medi-Cal rate for the applicable Medi-Cal covered services.

D. Beneficiary Notice

Upon court approval of this Revised Plan and the Beneficiary Notice, the Department will begin the process of mailing the Beneficiary Notice to the address of record of all current beneficiaries, as well as those individuals who were eligible at any time since June 27, 1997. This Beneficiary Notice is attached to the Revised Plan. The Beneficiary Notice will be sent to an estimated 11 million households. The cost of mailing this notice exceeds $3,000,000.

The Beneficiary Notice will be printed in English and Spanish and will be accompanied by a separate enclosure in which the following is printed in nine additional languages spoken by the largest number of non-English speaking beneficiaries in California:

> "REQUEST FOR NOTICE IN OTHER LANGUAGES
>
> If you were eligible for Medi-Cal anytime since June 27, 1997, or are eligible now, Medi-Cal may reimburse you for medical or dental bills that you paid. This notice tells you how to get more information. If you need this information in (insert appropriate language), please call (916) 403-2007." (Addresses February 8, 2006 court order, Issue 5.)

Telephone operators dedicated to the reimbursement process will be available to assist beneficiaries in translating their notice from English/Spanish to the nine (9) additional languages.

The printing and mailing of the Beneficiary Notices is dependent upon and will follow court approval. This Beneficiary Notice mailing activity will begin upon receipt of the court's approval of the Revised Plan. It will take several weeks to complete the mailing of all Beneficiary Notices to an estimated 11 million Medi-Cal households.

Medi-Cal providers will be sent additional and periodic bulletins to notify them of this reimbursement process and to remind them of their responsibilities to promptly reimburse beneficiaries who may have paid out-of-pocket expenses for Medi-Cal covered services.

E. Process of Beneficiary Claim Review/Adjudication

The process of beneficiary claims review/adjudication includes the following elements and approximate timelines (calendar days):

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Prior to receipt of a complete beneficiary claim:

The beneficiary may contact the Department's Beneficiary Service Center (which will be dedicated specifically to the new beneficiary reimbursement process and staffed by 40 telephone operators and correspondence staff at implementation) by mail or by phone. At the time of contact, the beneficiary will be directed to the appropriate staff (medical, dental, etc.) and will receive information on what is required in order to properly submit a complete claim and for the involved department or program to approve claims for reimbursement. The Department has developed a standardized claim form with directions on how to complete the form that can be mailed to the beneficiary at the time of initial contact and upon request. As a first step, the Department will mail a claim packet to the beneficiary and the beneficiary will be directed to mail the completed claim packet which includes: the Beneficiary Reimbursement Claim Form with beneficiary information, a completed STD 204 form; a summary itemizing the covered expense(s) for which the beneficiary paid including proof of payment that shows receipt and payment of a service(s) (in some cases a declaration might supplement other documentary evidence); a copy of his/her Medi-Cal Beneficiary Identification Card (BIC); the dates of service(s); the provider'(s) name(s) with address(es) and phone number(s) if known; and for those Medi-Cal services that would have required Medi-Cal authorization, documentation from the medical or dental provider that shows medical necessity for the service.

For CDHS fee for service claims:

Day 1 – The beneficiary's completed claim is received by the Department;

Day 2 to 15 –

Redistribute the completed claims to other involved departments or programs for adjudication when the claim, depending upon claim/service type, involves services administered outside of the Medi-Cal fee-for-service program (the adjudication timeline will begin anew from the date the other department or program receives the completed claim, as listed in "Day 1" above)[3]; or

2. The Department will acknowledge receipt of the beneficiary's claim in writing.

By Day 15 from receipt of the beneficiary's completed claim the Department will either:

Notify the beneficiary in writing that the claim has been denied. The written notice will include an explanation of the reason(s) for denial based upon the information submitted and a NOA explaining their hearing right and procedure to request a State Hearing,

[3] Redistribution to other involved departments or programs may delay the initial adjudication of a claim and subsequent notifications.

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2. Notify the beneficiary that additional information is required in order to process the claim, or

   Contact the healthcare provider by letter and request full reimbursement for the beneficiary. If the healthcare provider is a Medi-Cal provider and it is determined that the funds are recoupable, the letter will state the Department's intention to initiate the recoupment action against the Medi-Cal provider if the beneficiary is not promptly reimbursed. The Medi-Cal provider will be given 30 days from the date of the letter to comply with the request and provide written confirmation of the reimbursement to the beneficiary or to request a State Hearing.

   Note: If the Medi-Cal provider requests a State Hearing regarding the reimbursement decision or recoupment process, the request will be forwarded to the DSS/State Hearings Division (SHD) along with information that identifies both the Medi-Cal provider and the beneficiary who requested the reimbursement at issue in the State Hearing;

Day 16 to 60 – The Department will evaluate the healthcare provider's response to the Department's request for direct reimbursement to the beneficiary and continue processing the beneficiary's claim. If additional information is required, the claim is not complete and the reimbursement process may be delayed;

Day 60 to 120 –

- If reimbursement for the full amount has been made to the beneficiary by the healthcare provider(s) voluntarily, the Department will close the claim and send a letter to the beneficiary indicating that the claim was closed due to payment from the healthcare provider.

- If the Medi-Cal provider has not made full reimbursement, the Department will initiate recoupment from the Medi-Cal provider if appropriate.[4]

  If recoupment is appropriate, then the Department will notify the Medi-Cal provider that the Department will initiate recoupment proceedings against the Medi-Cal provider. The Department will permanently divert funds from the Medi-Cal provider sufficient to reimburse the claim in full, reimburse the beneficiary, and close the claim. The recoupment action will delay the reimbursement process timeline.

[4] Sufficient funds must be available to be permanently diverted from the enrolled provider's expected Medi-Cal payments at the time recoupment is initiated by the Department. If funds are not available from a provider for recoupment, then the Department will directly reimburse the beneficiary for the valid claim at the amount paid, not to exceed the rate established for the service under the Medi-Cal program. (California Welfare and Institutions Code, section 14019.3(i)(5).)

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If recoupment is not appropriate, the Department will directly reimburse the beneficiary for those services approved on the beneficiary's claim. Reimbursement may be up to the allowable Medi-Cal rate(s) for the specific Medi-Cal covered service(s), and shall be considered payment in full of the claim. The Department will also send a letter to the beneficiary indicating that the claim was paid along with pertinent claim payment information and information on requesting a State Hearing.

- If all or part of the beneficiary's claim is denied, the beneficiary will be sent a NOA explaining what was denied and why. The NOA will provide information on how to file for a State Hearing. The beneficiary has 90 days from the date of the NOA to request a State Hearing.

F. Criteria for Processing Beneficiary Claims

Claims must meet the following criteria in order to qualify for reimbursement. In some cases to satisfy the criteria a declaration might supplement other documentary evidence. A declaration shall not substitute for documentation of medical necessity: Claims that do not meet the following criteria will be denied:

The beneficiary was eligible for Medi-Cal at the time the service(s) was(were) provided;

The claimed service(s) was(were) provided on or after June 27, 1997;

The service(s) provided was(were) a Medi-Cal covered service—i.e., a Medi-Cal benefit at the time the service(s) was(were) rendered;

The beneficiary was eligible to receive the service(s) at the time the service(s) was(were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits;

The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.), with an itemized list of services covered by the payment, and to whom the payment was made;

The beneficiary has submitted a completed STD 204 form;

For those Medi-Cal services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider that shows medical necessity for the service(s);

The claimed cost(s) was(were) not required to meet co-payments, share of cost or other cost-sharing requirement(s);

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The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal/Denti-Cal, other Medi-Cal funded program, the healthcare provider or by a third party;

The beneficiary did not have other health coverage at the time the service(s) was(were) rendered that would have been obligated to pay the claimed cost(s);

Claims for Medi-Cal covered service(s) provided during the evaluation period for date(s) of service on or after February 2, 2006, and claims for Medi-Cal covered service(s) provided during the post approval period for date(s) of service on or after June 27, 1997, the service(s) must have been rendered by a provider who at the time the service(s) was(were) rendered was an active Medi-Cal authorized provider.

Submission timelines for a timely claim:

The claim(s) for service(s) that was(were) provided from June 27, 1997, through Month Day, Year[D1], must be received by the Department by Month Day, Year [D2],or within 90 days after issuance of the Medi-Cal card (addresses the February 8, 2006 trial court order, Issue 4), whichever is the longest period of time (to account for those claims in which the beneficiary's evaluation period was longer than a calendar year);

The claim(s) for service(s) that was(were) provided on or after Month Day, Year[D3], must be received by the Department within one calendar year after the date the service(s) was(were) rendered or within 90 days after issuance of the Medi-Cal card, whichever is the longest period of time (to account for those claims in which the beneficiary's evaluation period was longer than a calendar year) (Addresses the February 8, 2006 trial court order, Issue 4);

If either a State Hearing request or a claim was timely submitted and must be dismissed for a defect that can be cured, the Administrative Law Judge (ALJ) will refer the beneficiary back to the Department for evaluation of the claim. The ALJ's order will provide that the beneficiary may file a new or amended claim with the Department within 60 days after the issuance date of the ALJ's written dismissal decision, if the period for filing the claim is past, or within any period remaining to file a timely or amended claim, if that period is longer.

G. State Hearings- New Procedures

There are two claims adjudication outcomes that will lead to a new State Hearing procedure opportunity. This new procedure extends the State Hearing to both the beneficiary and the Medi-Cal provider. The adjudication outcomes are:

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Denial of the beneficiary's reimbursement claim based on failure to provide documentation that meets all adjudication criteria listed in Section F.

- This outcome generates a NOA and right to a State Hearing for the beneficiary.

2. Tentative reimbursement approval requiring recoupment of a Medi-Cal provider's funds.

   - This outcome generates a NOA and right to a State Hearing for the Medi-Cal provider.

1. Denial of a Claim Based on Failure to Meet All Adjudication Criteria

Claims that fail to provide documentation that meets all adjudication criteria will be denied and a NOA will be sent to the beneficiary. If the beneficiary requests a State Hearing to contest the validity of the denial, a State Hearing will be scheduled.

The hearing will include only the beneficiary and the Department, if the reason for the denial relates only to the beneficiary; i.e., the beneficiary was not eligible for Medi-Cal in the month the services were provided, the service for which reimbursement is requested is not a Medi-Cal benefit, the claim was incomplete, the request for a hearing was filed more than 90 days after the denial NOA was sent.

If the basis of the denial is an issue upon which there could be a dispute between the beneficiary and the Medi-Cal provider, the Medi-Cal provider of the service will be notified that the beneficiary has requested a hearing seeking reimbursement of funds they assert they paid to the Medi-Cal provider for Medi-Cal covered services. The Medi-Cal provider will be informed that if they contest the claim for reimbursement, they must participate in the State Hearing in order to represent their interests. The Medi-Cal provider will be informed that the State Hearing decision will result in a final decision on their obligation to reimburse the beneficiary and failure to represent their interests may subject them to recoupment actions. The Medi-Cal provider will have 30 days from the date of the notification letter to research the case and prepare arguments and evidence.

The Department will prepare a position statement that will set forth the evidence and the Department's determination of the party prevailing on the claim. The hearing will be scheduled with two weeks notice to all parties. All parties wishing to introduce documentary evidence must provide that evidence in advance of the hearing. The SHD will assure that all parties have copies of the documentary evidence prior to the hearing. At the hearing, the Department, the beneficiary, and the Medi-Cal provider will have an opportunity to present testimony and arguments in support of their position and to cross-examine witnesses presented by other parties. At the conclusion of the hearing, the record will be closed and the ALJ will issue a written decision that the parties will receive in the mail.

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The rules for State Hearing will follow the regulations set forth in the California Department of Social Services Manual of Policies and Procedures Division 22, to the extent practicable, except as otherwise provided in this Plan.

2. Ensuring Beneficiary Payments through Recoupment of a Medi-Cal Provider's Funds

In the February 8, 2006 court order, the court required the Department to amend the previous implementation plan to provide, "a detailed description of the steps and procedures the Department intends to take to 'ensure payment to a beneficiary by a provider.'" In order to comply, the Department must create a new procedure that may require recoupment of Medi-Cal funds from a Medi-Cal provider that exceed the Medi-Cal rate, if in fact the beneficiary actually paid more for a Medi-Cal covered service than the Medi-Cal maximum rate for that service. The Department has not yet promulgated regulations specific to W&I Code Section 14019.3 defining the specific mechanism to recoup funds from Medi-Cal providers including those in excess of the Medi-Cal rate. This Plan and the subsequent court order in this matter are intended to provide confirmation that the involved department or program responsible for final adjudication of a Beneficiary Reimbursement Claim has the legal authority to implement a monetary recoupment mechanism, to permanently redirect a provider's Medi-Cal reimbursement funds to satisfy an adjudicated Beneficiary Reimbursement claim including the new State Hearing process to provide joint and exclusive administrative remedy to disputes by all involved parties, until such time as the Department promulgates regulations specific to the mechanism of recoupment authorized under California Welfare and Institutions Code Section 14019.3.

The new procedures were designed to assure the beneficiary will receive either full reimbursement, or in the alternative the due process to which they are entitled while also allowing a Medi-Cal provider the right to due process to provide evidence that the proposed reimbursement and recoupment is not correct.

The current State Hearing process for beneficiaries resolves disputes involving any adverse actions related to Medi-Cal eligibility or benefits. That process was enacted pursuant to Welfare and Institutions Code, Section 10950 et. seq. That process is not a remedy for Medi-Cal providers to resolve other Medi-Cal payment/funding issues.

This new State Hearing process includes the following steps:

> The involved department or program will notify the Medi-Cal provider that the involved department or program intends to recoup funds the Medi-Cal provider received from the beneficiary in order to fully to reimburse the beneficiary. The Medi-Cal provider will be informed that it may voluntarily reimburse the beneficiary and bill Medi-Cal for the services rendered, or if it disputes the validity of reimbursement and proposed recoupment, it may request a State Hearing. The involved department or program will receive the Medi-Cal provider's State

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Hearing request and forward it to DSS along with information about the beneficiary claim so that DSS can administer the new State Hearing process.

DSS will send an acknowledgement letter to all parties to the hearing. This letter will inform parties of their right and opportunity to participate in the hearing and that a decision may be made against their interests, even if they do not participate.

A party will have 30 days to prepare for the hearing after receiving this information. A party may request additional time and upon good cause, SHD will grant additional preparation time.

The involved department or program will prepare a position statement that explains the reason for the state action and includes all claims documentation timely submitted by the beneficiary and the Medi-Cal provider. The position statement will include the involved department or program's evaluation of the documentation and the involved department or program's proposed disposition of the claim. The position statement will be mailed to the beneficiary and the Medi-Cal provider two weeks before the scheduled hearing.

The involved department or program, the beneficiary, and Medi-Cal provider will each represent their own interests at the hearing and provide documentation and testimony to support their position. Any party may designate an authorized representative to represent them in accordance with the California Department of Social Services Manual of Policies and Procedures Division 22, as applicable, and guidelines, criteria and information otherwise provided in this Plan.

All State Hearing decisions resulting in beneficiary reimbursement will be forwarded directly from DSS to the involved department or program for processing of reimbursement if so ordered. (Addresses the February 8, 2006 trial court order, Issue 3.)

The critical steps that distinguish this new State Hearing process from the current process include:

The new State Hearing process shall jointly provide the beneficiary and the Medi-Cal provider the sole and exclusive administrative remedy regarding their respective interests regarding the claim for reimbursement and the funds potentially subject to recoupment. The State Hearing will afford both the beneficiary and the Medi-Cal provider the opportunity to present evidence, through documents and/or testimony, to challenge any evidence presented against them, and to present arguments for their position. The beneficiary, Medi-Cal provider, and involved department or program are all parties to the State Hearing.

A Medi-Cal provider will be permitted 30 days from the date of the NOA regarding the intended recoupment action to request a State Hearing to contest the recoupment of Medi-Cal funds. If the court determines a longer period is required, the time within which the beneficiary's claim will be adjudicated must be extended by the same number of days.

A State Hearing to determine the correctness of the involved department or program determination regarding the reimbursement claim and recoupment action may be held by telephone, unless in the discretion of the ALJ, the interests of justice require a videoconference or in person hearing. The primary relevant evidence in these cases will be documents, and all parties will have all evidence in hand at the time of the hearing.

A postponement or continuance of the State Hearing granted to one party will extend, by an equal number of days, the date by which a final decision to all parties is due in the case.

A request for a State Hearing tolls the beneficiary's 120-day payment timeline for reimbursement of a completed claim to determine if evidence submitted by the Medi-Cal provider rebuts the beneficiary claim.

A requirement that both the Medi-Cal provider and the beneficiary must agree to withdraw a hearing request and if one party disagrees, the State Hearing will proceed.

The Medi-Cal provider may authorize a "designated hearing representative" to present their evidence; this may be an attorney, employee of their practice/company, or anyone else.

The SHD shall have the authority to adopt such other procedures and process as are advisable or required for the conduct and adjudication of the beneficiary reimbursement State Hearings by All County Letter (ACL.) Any ACL setting forth SHD procedures for beneficiary reimbursement hearings shall have the force and effect of law from the time the ACL is issued for 30 months. At the end of that period, the SHD must adopt regulations setting forth the procedures and processes for the beneficiary reimbursement hearings.

The Medi-Cal provider and the beneficiary will have the joint and exclusive opportunity to have the matter adjudicated by an ALJ. At the hearing evidence will be taken and discretion in the determination of facts will be vested in the ALJ. After the record is closed the ALJ shall issue an administrative decision. The reimbursement and recoupment process will be stayed pending the outcome of the State Hearing. Any appeal of the final decision by the beneficiary and/or the Medi-Cal provider shall proceed under California Code of Civil Procedure, section 1094.5.

The involved department or program may implement this new procedure through the establishment of guidelines, criteria and information bulletins published in Medi-Cal Provider Manuals, Medi-Cal Provider Bulletins, ACL, Beneficiary Notices, and Medi-Cal beneficiary publications. Pursuant to W&I Code, section 14019.3(j), "Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, this section may be implemented with a provider bulletin or similar notification, without any further regulatory action."

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State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

IF YOU WERE ELIGIBLE FOR MEDI-CAL ANYTIME SINCE JUNE 27, 1997, OR ARE ELIGIBLE NOW MEDI-CAL MAY REIMBURSE YOU FOR MEDICAL OR DENTAL BILLS YOU PAID

Conlan v. Bontá; Conlan v. Shewry

As the result of two court decisions, you may be able to be repaid for some medical expenses you paid. The California Department of Health Services (CDHS) will assist you in getting your money back if all criteria below are met:

1. You received a medically necessary medical or dental service during one or all of these time periods:
   - ✓ The 3-month period prior to the month you applied for the Medi-Cal program;
   - ✓ From the date you applied for the Medi-Cal program until the date your Medi-Cal card was issued,
   - ✓ After your Medi-Cal card was issued (includes excess co-payment and excess share of cost charges), and
2. You paid for your medical or dental service; or another person paid for your medical or dental service on your behalf. You will be asked to provide proof that the medical or dental service was paid for by you or the other person, and
3. You received the medical or dental service from a Medi-Cal enrolled provider (note: you do not need to have received the service from a Medi-Cal enrolled provider if you received the medical or dental service during the 3-month period prior to applying to Medi-Cal, or you received the services on or after June 27, 1997 but before February 2, 2006 and you had applied for Medi-Cal but not yet received a Medi-Cal card), and
4. For those Medi-Cal services that were provided and would have required Medi-Cal authorization, you have documentation from the medical or dental provider that shows medical necessity for the service, and
5. You were Medi-Cal eligible to receive that specific medical or dental service, and
6. The medical or dental service was a benefit under the Medi-Cal program, and
7. The medical or dental service was provided on or after June 27, 1997, and
8. After you received your Medi-Cal card, you contacted your provider and showed your provider your Medi-Cal card and the provider would not give you your money back.

Important dates and time frames:

- For services received June 27, 1997 through Month Day, Year[pf1], you must submit your claim by Month Day, Year [pf2]or within 90 days after issuance of the Medi-Cal card, which ever is longer.
- For services received on or after Month Day, Year[pf3],, you must submit your claim within one year of receipt of services or within 90 days after issuance of the Medi-Cal card, which ever is longer.

For more information or to file a claim, you MUST call or write to Medi-Cal at:

For Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims:	**For Dental Claims:**
California Department of Health Services Beneficiary Services P.O. Box 13008 Sacramento, CA 95813-9998 **(916) 403-2007 TDD: (916) 635-6491**	Denti-Cal Beneficiary Services P.O. Box 15539 Sacramento, CA 95852-1539 **(916) 403-2007 TDD: (916) 635-6491**

-- DON'T FORGET TO KEEP ALL RECEIPTS FOR THE MEDICAL AND DENTAL CARE YOU RECEIVE --

Medi-Cal will review your claim for repayment and send you a letter with a check or a denial letter that tells you the reason for denial. If Medi-Cal denies your request for payment, you may ask for a fair hearing. The denial letter will tell you how to ask for a fair hearing.

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Medicare/Medi-Cal Coverage: Starting January 1, 2006, medications covered under Medicare Part D will not be a covered benefit under the Medi-Cal Program and are not eligible for reimbursement. For questions regarding Medicare Part D contact 1-800-Medicare.

SI USTED ERA ELEGIBLE PARA MEDI-CAL EN CUALQUIER MOMENTO DESDE EL 27 DE JUNIO DE 1997, O AHORA ES ELEGIBLE, ES POSIBLE QUE MEDI-CAL LE REEMBOLSE POR CUENTAS MÉDICAS O DENTALES QUE USTED HAYA PAGADO

Conlan v. Bontá; Conlan v. Shewry

Como resultado de dos decisiones de la corte, es posible que usted pueda ser reembolsado/a por algunos costos médicos que usted pagó. El Departamento de Servicios de Salud de California (California Department of Health Services-CDHS) le asistirá en conseguir el reembolso de su dinero si satisface todos los requisitos mencionados abajo:

1. Usted recibió un servicio médico o dental que fue médicamente necesario durante uno o todos estos periodos:
   - ✓ En el período de 3 meses antes del mes que usted solicitó para el programa de Medi-Cal;
   - ✓ A partir de la fecha que usted solicitó para el programa de Medi-Cal hasta que su tarjeta de Medi-Cal fue expedida,
   - ✓ Después de que se expida su tarjeta médica (incluye exceso del co-pago y exceso de cargos de parte del costo, y
2. Usted pagó por su servicio médico o dental; o
   otra persona pagó por su servicio médico o dental de parte de usted (le pedirán proveer la prueba del servicio médico o dental que fue pagado por usted o por la otra persona, tal como un recibo o un cheque cancelado con una lista detallada de los servicios cubiertos por el pago), y
3. Usted recibió el servicio médico o dental de un proveedor inscrito en Medi-Cal (nota: usted no necesita haber recibido el servicio de un proveedor inscrito en Medi-Cal si usted recibió el servicio médico o dental durante el período de tres meses antes de solicitar Medi-Cal), y
4. Usted tiene una receta médica, orden o nota de un proveedor médico o dental, o evaluación de sus necesidades del programa Servicios de Casa y Cuidado Personal (In-Home Supportive Services) del condado por el servicio médico o dental que usted recibió y cuál usted pagó (a excepción de una visita de oficina con el médico/dentista, que no requiere una receta médica), y
5. Usted tenia elegibilidad de Medi-Cal para recibir ese servicio especifico médico o dental, y
6. El servicio médico o dental fue un beneficio bajo el programa de Medi-Cal, y
7. El servicio médico o dental fue proporcionado en o después del 27 de junio de 1997, y
8. Después de que usted recibió su tarjeta de Medi-Cal, usted contactó a su proveedor y le demostró a su proveedor su tarjeta de Medi-Cal y el proveedor no le reembolsó su dinero.

Fechas y marcos de tiempo importantes:

- Para los servicios recibidos el 27 de junio de 1997 al ~~30 de septiembre del 2006~~, usted debe presentar su reclamo antes del ~~1º de octubre del 2007~~, o en el plazo de 90 días después de que se expida la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.
- Para los servicios recibidos en o después del ~~1º de octubre del 2006~~, usted debe presentar su reclamo dentro del plazo de un año de la fecha que recibió los servicios, o en el plazo de 90 días después de que se expida la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.

Para más información o presentar un reclamo, usted DEBE llamar o escribir a Medi-Cal al:

Para Reclamos Médicos, de Salud Mental, de Drogas y Alcohol, y de Servicios de Casa y Cuidado Personal (Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Service Claims): California Department of Health Services Beneficiary Services P.O. Box 13008 Sacramento, CA 95813-9998 **(916) 403-2007 TDD: (916) 635-6491**	**Para Reclamos Dentales (Dental Claims):** Denti-Cal Beneficiary Services P.O. Box 15539 Sacramento, CA 95852-1539 **(916) 403-2007 TDD: (916) 635-6491**

--NO SE OLVIDE DE GUARDAR TODOS LOS RECIBOS DEL CUIDADO MÉDICO Y DENTAL QUE USTED RECIBE--
Medi-Cal revisará su reclamo para el reembolso y le enviará una carta con un cheque o una carta de negación que le explicará la razón del porqué fue negado/a. Si Medi-Cal niega su pedido de pago, usted puede pedir una audiencia justa. La carta de negación le dirá cómo pedir una audiencia justa.

Cobertura de Medicare/Medi-Cal: Empezando el 1º de enero del 2006, las medicaciones cubiertas bajo Medicare Parte D no serán un beneficio cubierto bajo el programa de Medi-Cal y estas medicaciones no son elegibles para el reembolso. Para las preguntas con respecto a Medicare Parte D llame al 1-800-Medicare.

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BILL LOCKYER
Attorney General of the State of California
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Supervising Deputy Attorney General
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Deputy Attorney General
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Fax: (415) 703-5480

Attorneys for Respondents Sandra Shewry, in her Official Capacity as Director of the California Department of Health Services; and California Department of Health Services

ENDORSED
FILED
San Francisco County Superior Court
NOV 7 2006
GORDON PARK-LI, Clerk
BY: ERICKA LARNAUTI
Deputy Clerk

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

KEVIN CONLAN, ASHER SCHWARZMER and THOMAS STEVENS,

Petitioners,

v.

SANDRA SHEWRY, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES; CALIFORNIA DEPARTMENT OF HEALTH SERVICES, et al.,

Respondents.

CASE NO. 987697

~~[proposed]~~ ORDER APPROVING RESPONDENTS' REVISED IMPLEMENTATION PLAN AND PROPOSED NOTICE TO BENEFICIARIES

Good cause appearing, Respondents' Revised Implementation Plan and Proposed Notice to Beneficiaries as submitted to this Court are hereby approved. Respondents may proceed to distribute the Notice to Beneficiaries and implement the Revised Implementation Plan.

The start date for the Revised Implementation Plan shall be November 16, 2006 Accordingly, the dates set forth in the Revised Implementation Plan at page 9 (D1, D2, D3) shall be as follows: D1: November 16, 2006; D2: November 16, 2007; and D3: November 16, 2006.

Respondents shall provide reports to petitioners, with copies to the Court, twice per year for the next two years, that will include at least the following information regarding the claims submitted under the Plan

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1. The number of completed claims received by the California Department of Health Services (CDHS) under the Plan.

2. The number of claims redirected to sister agencies by CDHS;

3. The number of fee-for-service claims paid by CDHS; and

4. The number of fee-for-service claims denied by CDHS.

The Court shall retain jurisdiction over this matter for all purposes for two years from the date of this order

IT IS SO ORDERED.

DATED: 11/17/06

PETER J. BUSCH
The Hon. Peter J. Busch
Judge of the Superior Court

11-17-06
Approved as to Form
Michael Keys

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State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

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5. You were Medi-Cal eligible to receive that specific medical or dental service.
6. The medical or dental service was a benefit under the Medi-Cal program.
7. The medical or dental service was provided on or after June 27, 1997.
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For more information or to file a claim, you MUST call or write to Medi-Cal at:

For Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims:	For Dental Claims:
California Department of Health Services **Beneficiary Services** **P.O. Box 138008** **Sacramento, CA 95813-8008** **(916) 403-2007 TDD: (916) 635-6491**	**Denti-Cal** **Beneficiary Services** **P.O. Box 526026** **Sacramento, CA 95852-6026** **(916) 403-2007 TDD: (916) 635-6491**

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State of California—Health and Human Services Agency

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SANDRA SHEWRY
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SI USTED ERA ELEGIBLE PARA MEDI-CAL EN CUALQUIER MOMENTO DESDE EL 27 DE JUNIO DE 1997, O AHORA ES ELEGIBLE, ES POSIBLE QUE MEDI-CAL LE REEMBOLSE POR CUENTAS MÉDICAS O DENTALES QUE USTED HAYA PAGADO

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Como resultado de dos decisiones de la corte, es posible que usted pueda ser reembolsado/a por algunos costos médicos que usted pagó. El Departamento de Servicios de Salud de California (California Department of Health Services-CDHS) le asistirá en conseguir el reembolso de su dinero si satisface todos los requisitos mencionados abajo:

1. Si usted recibió un servicio médico o dental que fue médicamente necesario durante estos períodos:
   - ✓ En el período de 3 meses antes del mes que usted solicitó para el programa de Medi-Cal,
   - ✓ A partir de la fecha que usted solicitó el programa de Medi-Cal hasta que su tarjeta de Medi-Cal fue expedida,
   - ✓ Después de que se expida su tarjeta médica (incluye exceso del pago parcial y exceso de cargos de parte del costo).
2. Si usted pagó por su servicio médico o dental, u otra persona pagó por su servicio médico o dental de parte suya. Usted va ser requerido que provea pruebas del servicio medico o dental, que fue pagado por usted u otra persona.
3. Si usted recibió el servicio médico o dental de un proveedor inscrito en Medi-Cal (nota: usted no necesita haber recibido el servicio de un proveedor inscrito en Medi-Cal si usted recibió el servicio médico o dental durante el período de tres meses antes de solicitar Medi-Cal).
4. Si usted tiene, una autorización de un proveedor médico o dental, y tienes documentación del proveedor medico o dental que enseña que los servicios fueron necesarios.
5. Si usted tenía elegibilidad de Medi-Cal para recibir ese servicio específico médico o dental.
6. El servicio médico o dental fue un beneficio bajo el programa de Medi-Cal.
7. El servicio médico o dental fue proporcionado en o después del 27 de junio de 1997.
8. Después de que usted recibió su tarjeta de Medi-Cal, usted contactó a su proveedor y le mostró a su proveedor su tarjeta de Medi-Cal y el proveedor no le reembolsó su dinero.

Fechas y horarios importantes:

- Para los servicios recibidos el 27 de junio de 1997 al 16 de noviembre del 2006, usted debe presentar su reclamo antes del 16 de noviembre del 2007, o en el plazo de 90 días después de que se recibió la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.
- Para los servicios recibidos en o después del 16 de noviembre del 2006, usted debe presentar su reclamo dentro del plazo de un año de la fecha que recibió los servicios, o en el plazo de 90 días después de que se recibió la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.

Para más información o presentar un reclamo, usted DEBE llamar o escribir a Medi-Cal a las siguientes direcciones

Para Reclamos Médicos, de Salud Mental, de Drogas y Alcohol, y de Servicios de Casa y Cuidado Personal (Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Service Claims):
California Department of Health Services
Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008
(916) 403-2007 TDD: (916) 635-6491

Para Reclamos Dentales (Dental Claims)

Denti-Cal
Beneficiary Services
P.O. Box 526026
Sacramento, CA 95852-6026
(916) 403-2007 TDD: (916) 635-6491

--NO SE OLVIDE GUARDAR TODOS LOS RECIBOS DEL LOS SERVICOS MÉDICO Y DENTAL QUE USTED RECIBIO--

Medi-Cal revisará su reclamo para el reembolso y le enviará una carta con un cheque o una carta de negación que le explicará la razón del porqué fue negado. Si Medi-Cal niega su petición de pago, usted puede pedir una Apelación al Estado. La carta de negación le dirá cómo pedir la Apelación al Estado.

Cobertura de Medicare/Medi-Cal: Empezando el 1º de Enero del 2006, los medicamentos cubiertas bajo Medicare Parte D no serán un beneficio cubierto bajo el programa de Medi-Cal y estos medicamentos no son elegibles para el reembolso. Para preguntas sobre Medicare Parte D llame al 1-800-Medicare.

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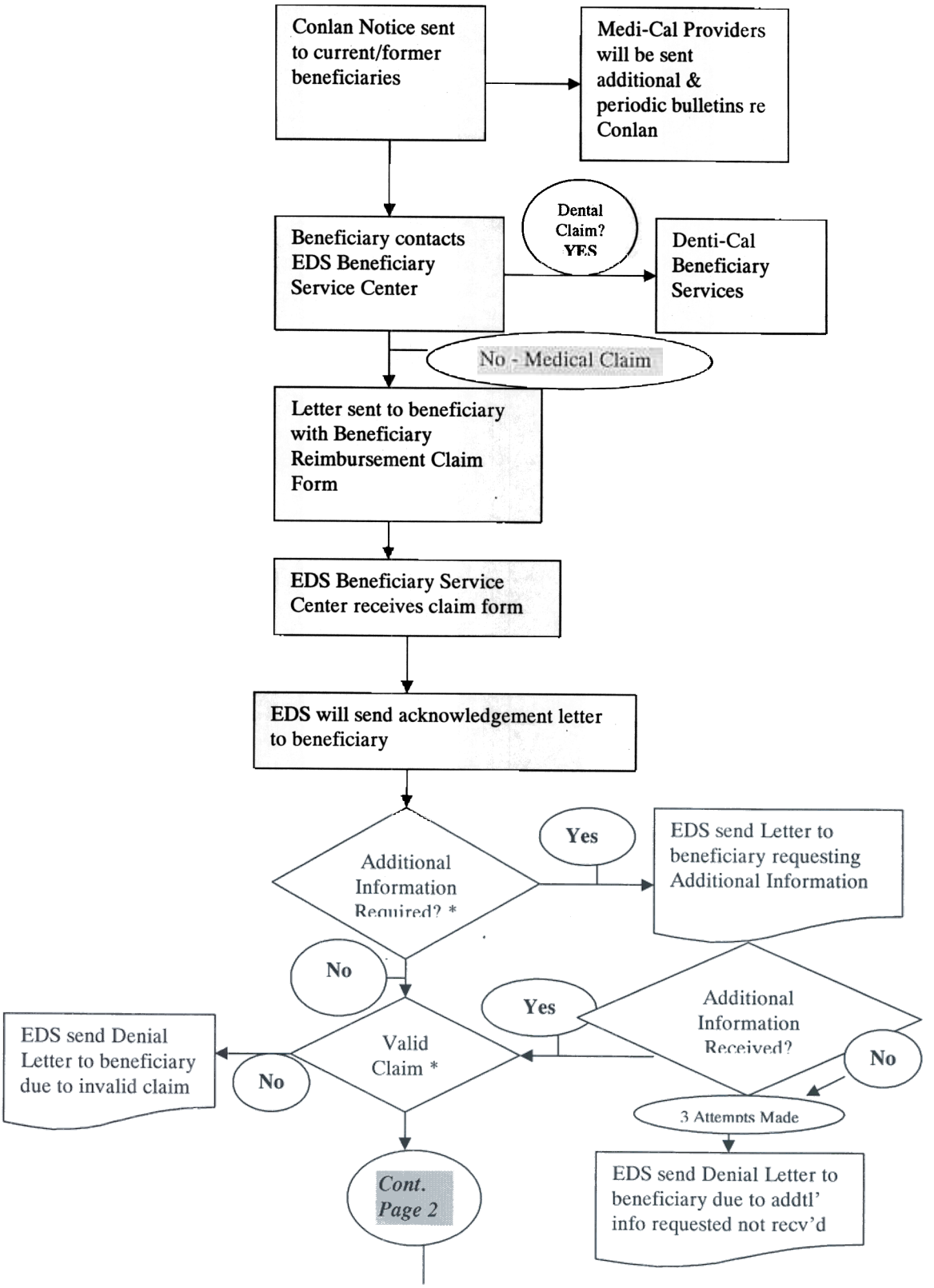
Medi-Cal Managed Care
Conlan Claim Process



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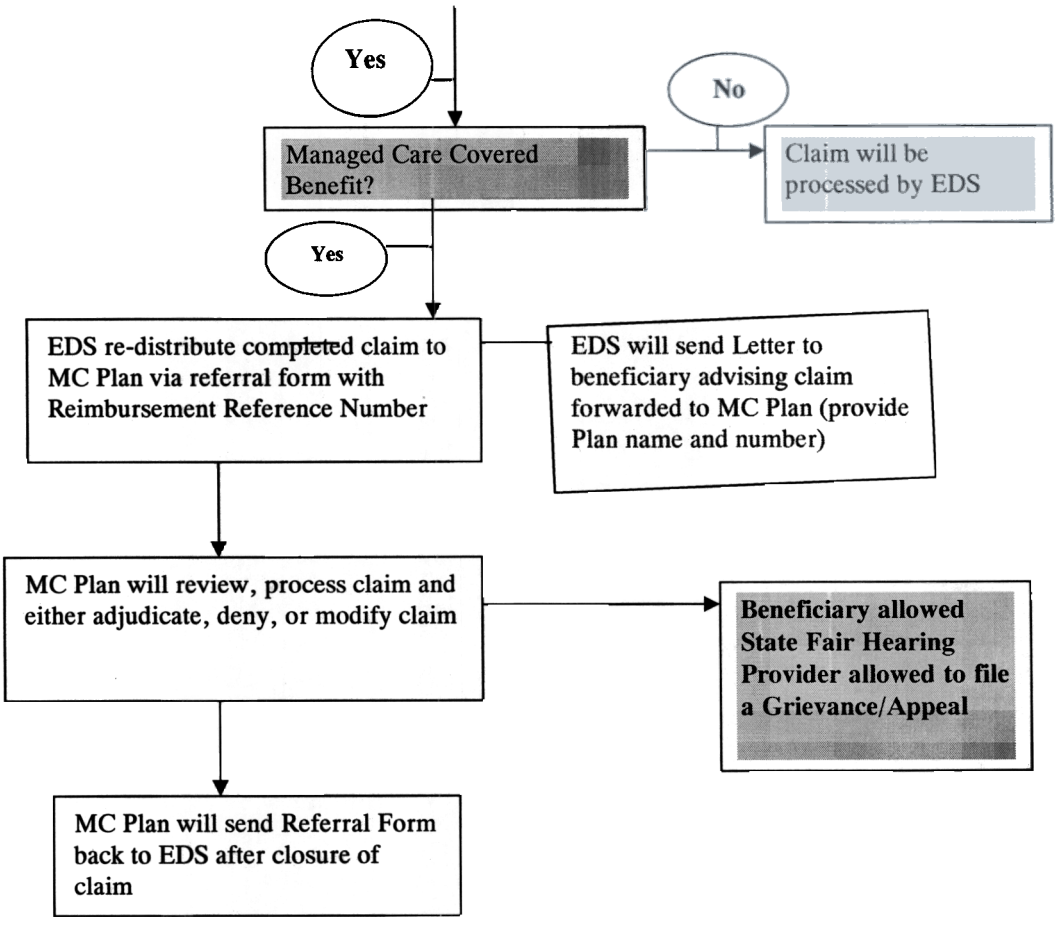
Medi-Cal Managed Care
Conlan Claim Process



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Beneficiary Reimbursement Claim Referral

Claim Referred To:

☐ ADP ☐ DMH ☐ IHSS ☐ Dental ☐ Managed Care

CRM Issue #:_____

Date Claim Received:_____ Payment Due Date:

Claim Information

Beneficiary Name:_____

Address:_____

Date(s) of Service_____ _____

Procedure Code(s)_____ _____

Beneficiary Paid Amount:$_____

Medi-Cal Rate:$_____

Medi-Cal Provider? Y N

Provider Number:_____

COMMENTS:_____

_____

_____

Analyst:_____ Phone #:_____

Program Use Only

Date Case Received:_____

☐ Paid Payment Date:_____ Amount Paid:_____

☐ Denied Denial Date:_____

Denial Reason:_____

Analyst: _____ Phone #:_____

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 13, 2020

ALL PLAN LETTER 20-013

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: PROPOSITION 56 DIRECTED PAYMENTS FOR FAMILY PLANNING SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed health care plans (MCPs) with guidance on directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for the provision of specified family planning services with dates of service on or after July 1, 2019.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the California Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill (AB) 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-101-3305 appropriates Proposition 56 funding to support family planning services for Medi-Cal beneficiaries, which DHCS is implementing in managed care in the form of a directed payment arrangement for specified family planning services in accordance with DHCS' developed payment methodology outlined below.[2] On June 30, 2019, DHCS requested approval from the federal Centers for Medicare & Medicaid Services (CMS) for this directed payment arrangement in accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438.6(c)(2).[3] CMS approval of this directed payment arrangement is still pending.

Subject to future budgetary authorization and appropriation by the California Legislature and the necessary federal approvals of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis for the duration

[1] This APL does not apply to Prepaid Ambulatory Health Plans or Rady Children's Hospital.
[2] AB 74 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB74.
[3] Part 438 of the CFR can be accessed at: https://www.ecfr.gov/cgi-bin/text-idx?SID=c131f365759360ca3555585f2b6a1b6e&mc=true&node=pt42.4.438&rgn=div5.

of the program. The requirements of this APL may change, if required, to obtain CMS approval for this directed payment arrangement or to comport with future State legislation.

This directed payment program is intended to enhance the quality of patient care by ensuring that Providers in California who offer family planning services receive enhanced payment for their delivery of effective, efficient, and affordable health care services. Timely access to vital family planning services is a critical component of beneficiary and population health. In particular, this program is focused on the following categories of family planning services:

- Long-acting contraceptives
- Other contraceptives (other than oral contraceptives) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures (for females and males)

Under federal law,[4] "a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive such [family planning] services under Section 1396d(a)(4)(C) of this title…."[5] Therefore, Members must be allowed freedom of choice of family planning Providers, and may receive such services from any qualified family planning Provider, including out-of-Network Providers, without the need to obtain prior authorization. DHCS managed care contracts specify the requirements pertaining to family planning services in Exhibit A, Attachment 9, Access and Availability.[6]

POLICY:
Subject to obtaining the necessary federal approvals and budgetary authorization and appropriation by the California Legislature, DHCS is requiring MCPs, either directly or through their delegated entities and Subcontractors, to pay qualified contracted and non-contracted Providers[7] a uniform and fixed dollar add-on amount for the specified

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[4] *See* Title 42 of the United States Code (U.S.C.), Section 1396a(a)(23)(B).
[5] "[F]amily planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies[.]" 42 U.S.C. Section 1396d(a)(4)(C).
[6] MCP boilerplate contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[7] A qualified Provider is a Provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish family planning

family planning services (listed below) provided to a Medi-Cal managed care member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D), with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint for this program, which will be made available on DHCS' Directed Payments Program website upon CMS approval.[8]

MCPs are responsible for ensuring that qualifying family planning services are reported to DHCS in encounter data pursuant to APL 14-019, "Encounter Data Submission Requirements" using the procedure codes in the table below. MCPs are responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided. MCPs must include oversight in their utilization management processes, as appropriate. The uniform dollar add-on amounts of the directed payments vary by procedure code:

Procedure Code[9]	Description	Uniform Dollar Add-on Amount
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	$2,727.00
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00
J3490U8	DEPO-PROVERA	$340.00
J7303	CONTRACEPTIVE VAGINAL RING	$301.00
J7304	CONTRACEPTIVE PATCH	$110.00

services to a member. *See* Title 22 California Code of Regulations (CCR), Section 51200. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.

[8] The preprint will be available upon approval by CMS. DHCS' Directed Payments Program website is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

[9] Services billed for the following Current Procedural Terminology codes with modifiers UA or UB are excluded from these directed payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.

J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00
11976	REMOVE CONTRACEPTIVE CAPSULE	$399.00
11981	INSERT DRUG IMPLANT DEVICE	$835.00
58300	INSERT INTRAUTERINE DEVICE	$673.00
58301	REMOVE INTRAUTERINE DEVICE	$195.00
81025	URINE PREGNANGY TEST	$6.00
55250	REMOVAL OF SPERM DUCT(S)	$521.00
58340	CATHETER FOR HYSTEROGRAPHY	$371.00
58555	HYSTEROSCOPY DX SEP PROC	$322.00
58565	HYSTEROSCOPY STERILIZATION	$1,476.00
58600	DIVISION OF FALLOPIAN TUBE	$1,515.00
58615	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00
58661	LAPAROSCOPY REMOVE ADNEXA	$978.00
58670	LAPAROSCOPY TUBAL CAUTERY	$843.00
58671	LAPAROSCOPY TUBAL BLOCK	$892.00
58700	REMOVAL OF FALLOPIAN TUBE	$1,216.00

The uniform dollar add-on amounts for these family planning services must be in addition to whatever other payments eligible Providers would normally receive from the MCP, or the MCP's delegated entities and Subcontractors. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs,[10] and Cost-Based Reimbursement Clinics[11] are not eligible to receive this uniform dollar add-on directed payment.

[10] MCP contract, Exhibit E, Attachment 1, Definitions.
[11] Cost-Based Reimbursement Clinics are defined in Welfare and Institutions Code Section 14105.24, which is located at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14105.24&lawCode=WIC, as well as Supplement 5 to Attachment 4.19-B of the State Plan, which is located at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement%205%20to%20Attachment%204.19-B.pdf.

Data Reporting

Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, procedure code, service month, payor (i.e., MCP, delegated entity, or Subcontractor), and the Provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports shall be submitted in a consumable file format (i.e., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager.

MCPs must submit updated reports each subsequent quarter in the same format as the initial submission until the MCP considers the report to be complete. Each updated report must replace any prior reports. MCPs must submit the updated quarterly report in the appropriate file format and include an attestation that the MCP considers the report complete.

MCPs must continue to submit encounter data for the specified procedure codes as required by DHCS; however, there are no new encounter data submission requirements associated with this APL.

Payment and Other Financial Provisions

For clean claims or accepted encounters with dates of service between July 1, 2019, and the date the MCP receives payment from DHCS, the MCP must ensure that payments required by this APL are made within 90 calendar days of the date the MCP receives payments accounting for the projected value of the directed payments from DHCS. From the date the MCP receives payment onward, the MCP must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim[12] or accepted encounter for qualifying services, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for applicable family planning services received by the MCP more than one (1) year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the affected Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances

[12] A "clean claim" is defined in 42 CFR Section 447.45(b).

related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Providers. This communication must, at a minimum, include a description of how payments will be processed, how to file a grievance, and how to determine who the payor will be.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement shall be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint, which will be made available on the DHCS' Directed Payments Program website upon CMS approval. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

MCPs are further responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and Subcontractors.

Subject to future budgetary authorization and appropriation by the California Legislature and CMS approval of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis in future years. Please note that the requirements of this APL may change if required for CMS approvals applicable to this directed payment arrangement or as required in future budgetary authorization and appropriation by the California Legislature.

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 15, 2020

ALL PLAN LETTER 20-014

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: PROPOSITION 56 VALUE-BASED PAYMENT PROGRAM DIRECTED PAYMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on value-based directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), to Network Providers for qualifying services tied to performance on designated health care quality measures in the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care.

BACKGROUND:
On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

Assembly Bill 74 (Ting, Chapter 23, Statutes of 2019), Section 2, Item 4260-103-3305 appropriates Proposition 56 funds for State Fiscal Year (SFY) 2019-20, SFY 2020-21, and SFY 2021-22, pursuant to Welfare and Institutions Code (WIC) section 14188.1, including a portion to be used for directed payments in managed care according to the DHCS-developed payment methodology outlined below.[2]

Senate Bill 78 (Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2019) added Article 5.8 (commencing with section 14188) to WIC. In alignment with the Governor's Budget, this article requires DHCS to develop a value-based payment (VBP) program for the managed care delivery system to provide payments to Network Providers aimed at improving health care in the domains of prenatal and postpartum

[1] This APL does not apply to Prepaid Ambulatory Health Plans, Rady Children's Hospital, or SCAN Health Plan.
[2] California Law is searchable at http://leginfo.legislature.ca.gov/faces/codes.xhtml.

care, early childhood prevention, chronic disease management, and behavioral health care.[3]

On January 17, 2019, DHCS issued APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, which describes how DHCS evaluates Network Provider status and establishes requirements that must be satisfied in order for Network Providers to be eligible for directed payments.[4]

On June 21, 2019, DHCS released the VBP program specifications outlining the measures and payment triggers for each domain on the "Value Based Payment Program" webpage on the DHCS website.[5] The specifications provide an explanation for each VBP program measure, the source for each measure, and the appropriate procedure codes.[6] DHCS selected the measures in each domain in coordination with various professional and medical organizations and considered several factors, including but not limited to, stakeholder and advocate feedback, whether or not a measure aligns with DHCS' quality efforts, the number of impacted Members, and whether or not sufficient administrative support is available for the measure.

On June 30, 2019, DHCS requested approval from the Centers for Medicare and Medicaid Services (CMS) to implement this directed payment arrangement, in accordance with Title 42 of the Code of Federal Regulations (CFR) section 438.6(c)(2).[7] DHCS will make the CMS-approved preprint available on the "Directed Payments Program" webpage on the DHCS website upon CMS approval.[8]

POLICY:
Subject to obtaining the necessary federal approvals and consistent with 42 CFR section 438.6(c), MCPs, either directly or through their delegated entities and Subcontractors, must make directed payments for qualifying VBP program services (as defined below) for dates of service on or after July 1, 2019, in the specified amounts for the appropriate procedure codes, in accordance with the CMS-approved preprint. The directed payments shall be in addition to whatever other payments eligible Network

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[3] WIC sections 14188–14188.4.
[4] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[5] DHCS' Value Based Payment Program webpage is available at: https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx.
[6] The VBP program specifications are outlined in the *Value Based Payment Program Performance Measures* specifications, available at: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-Specifications-05.07.20.pdf.
[7] The CFR is searchable at: https://www.ecfr.gov/cgi-bin/ECFR?page=browse.
[8] DHCS' Directed Payments Program webpage is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

Providers would normally receive from the MCP or the MCP's delegated entities and Subcontractors.

VBP Program Domains, Measures, and Qualifying Services

MCPs must make value-based directed payments to eligible Network Providers for specific qualifying services tied to performance across four domains, as set forth in the VBP program specifications and the valuation summary.[9] The domains and measures eligible for directed payments and the corresponding amounts for qualifying services are:

Domain	Measure	Add-On Amount for Non-At-Risk Members	Add-On Amount for At-Risk Members[10]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
	Prenatal Care Visit	$70.00	$105.00
	Postpartum Care Visits	$70.00	$105.00
	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
	All Childhood Vaccines for Two Year Olds	$25.00	$37.50

[9] The VBP valuation summary is outlined in the "Proposition 56 Value Based Payment Program Measure Valuation Summary," available at: https://www.dhcs.ca.gov/provgovpart/Documents/VBP-VS.pdf.

[10] For qualifying events tied to Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, MCPs must make the add-on directed payments corresponding to at-risk Members. For qualifying events tied to all other Members, MCPs must make the add-on directed payments corresponding to non-at-risk Members.

	Blood Lead Screening	$25.00	$37.50
	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
	Diabetes Care	$80.00	$120.00
	Control of Persistent Asthma	$40.00	$60.00
	Tobacco Use Screening	$25.00	$37.50
	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
	Management of Depression Medication	$40.00	$60.00
	Screening for Unhealthy Alcohol Use	$50.00	$75.00

A qualifying service is a specific service, as set forth in the VBP program specifications, that is provided by an eligible Network Provider (see below) on or after July 1, 2019, to a Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). MCPs must ensure that qualifying services reported using the procedure codes indicated in the VBP program specifications are appropriate for the services being provided. Additionally, MCPs must report the qualifying services using the appropriate procedure codes in their encounter data submissions and provider network data submissions to DHCS.[11, 12] As MCPs are required to periodically report member-specific immunization information to an immunization registry, the California Immunization Registry (CAIR) will be used as a supplemental data source for the vaccine-related measures.[13, 14]

[11] For more information on encounter data, see APL 14-019: Encounter Data Submission Requirements, or any future iteration of that APL.
[12] For more information on provider network data, see APL 16-019: Managed Care Provider Data Reporting Requirements, or any future iteration of that APL.
[13] For more information on immunization requirements, see APL 18-004: Immunization Requirements or any future iteration of that APL.
[14] The CAIR website is available at: http://cairweb.org/

MCPs must make VBP directed payments for qualifying services provided by eligible Network Providers with dates of service on or after July 1, 2019, in accordance with the requirements outlined within the VBP program specifications. If applicable, for purposes of VBP directed payments, the "measurement year" for a given service is the calendar year in which that service was provided.

Network Providers Eligible for VBP Program Payments

Individual rendering Network Providers qualified to provide the VBP program services are eligible to receive VBP directed payments. In addition to the requirements outlined in APL 19-001, Network Providers must meet the following criteria to be eligible for the payments outlined above:

- Possess an individual (Type 1) National Provider Identifier (NPI); and
- Be practicing within their practice scope.

Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics (as defined in Supplement 5 to Attachment 4.19-B of California's Medicaid State Plan[15] and WIC section 14105.24) are not eligible Network Providers for the purposes of the VBP program. Services provided at or by these ineligible provider types are not eligible to receive VBP directed payments.

Data Reporting

Starting with the calendar quarter ending June 30, 2020, MCPs must report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to this APL, either directly by the MCP or by the MCP's delegated entities and Subcontractors. Reports must include all directed payments made for dates of service on or after July 1, 2019. MCPs must provide these reports in a format specified by DHCS, which, at a minimum, must include Health Care Plan code, VBP measure, service month, payer (i.e., MCP, delegated entity, or Subcontractor), and the Provider's National Provider Identifier. DHCS may require additional data as deemed necessary. All reports shall be submitted in a consumable file format (i.e., Excel or Comma Separated Values) to the MCP's Managed Care Operations Division (MCOD) Contract Manager.

Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, MCPs must submit an attestation to DHCS stating that no updated information is available. If updated information is available for the quarterly report, MCPs must submit the updated quarterly report in the

[15] Attachment 4.19-B of California's Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Attachment419-B.aspx.

appropriate file format and include an attestation that the MCP considers the report complete.

Payment and Other Financial Provisions

MCPs must ensure the payments required by this APL are made within 90 calendar days of receiving a clean claim[16] or accepted encounter for a qualifying VBP program service, for which the clean claim or accepted encounter is received by the MCP no later than one year after the date of service. MCPs are not required to make the payments described in this APL for clean claims or accepted encounters for qualifying VBP program services received by the MCP more than one year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's delegated entities or Subcontractors) and the Network Provider.

As required by the MCP contract for other payments, MCPs must have a formal procedure for the acceptance, acknowledgment, and resolution of Network Provider grievances related to the processing or non-payment of a directed payment required by this APL. In addition, MCPs must have a process to communicate the requirements of this APL to Network Providers. This communication must, at a minimum, include a description of the minimum requirements for a qualifying service, how payments will be processed, how to file a grievance, and how to determine the responsible payer.

Subject to obtaining the necessary federal approvals, the projected value of the directed payments will be accounted for in each MCP's actuarially certified, risk-based capitation rates. The portion of capitation payments to the MCP attributable to this directed payment arrangement shall be subject to a two-sided risk corridor. DHCS will perform the risk corridor calculation retrospectively and in accordance with the CMS-approved preprint, which will be made available on the DHCS "Directed Payments Program" webpage upon CMS approval. The parameters and reporting requirements of the risk corridor calculation will be specified by DHCS in a future revision of this APL or other similar future guidance.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. MCPs must communicate these requirements to all delegated entities and Subcontractors.

Please note that the requirements of this APL may change based upon future budgetary authorization and appropriation by the California Legislature or the status of the required CMS approvals applicable to this directed payment arrangement.

[16] A "clean claim" is defined in 42 CFR section 447.45(b).

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Table of Contents

State/Territory Name: California

State Plan Amendment (SPA) #: 20-0009

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

October 15, 2020

Jacey Cooper
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: TN 20-0009

Dear Ms. Cooper:

We have reviewed the proposed California State Plan Amendment (SPA) to Attachment 4.19-B, CA-20-0009, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on August 17, 2020. This SPA, effective July 1, 2020, allows for the continuation of an add-on to the fee-for-service (FFS) fee schedule rates for eligible ground emergency medical transports (GEMT) provided to Medi-Cal patients.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Blake Holt at 415-744-3754 or blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

Back to Agenda Back to Item

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20-0009

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY 2020 $ 5.074 (in thousands)
b. FFY 2021 $ 15,221 (in thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29 to Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for ground emergency medical transports with dates of service between July 1, 2020 and June 30, 2021.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Jacey Cooper

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: August 17, 2020

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 10/15/2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2020

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Todd McMillion

22. TITLE: Director, Division of Reimbursement Review

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Healthcare Common Procedure Coding System (HCPCS) Codes, as described below, effective July 1, 2019 through June 30, 2020, and July 1, 2020 through June 30, 2021. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with HCPCS Codes A0429 BLS Emergency, A0427 ALS Emergency, and A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

Methodology

For SFYs 2019-20 and 2020-21, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the HCPCS Code. The resulting total payment amount for HCPCS Codes A0429, A0427, A0433, and A0434 is $339.00, and for HCPCS Code A0225 is $400.72. The add-on is paid for each eligible HCPCS Code on a per-claim basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount listed in the table above for HCPCS Codes A0429, A0427, A0433, A0434 and A0225 are considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion
DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

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I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

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administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

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3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

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i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

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ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (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 the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

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4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

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c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

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4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

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M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS 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.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

For 20200402 BOD Review Only

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 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.
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).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

For 20200402 BOD Review Only

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	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.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

For 20200402 BOD Review Only

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

For 20200402 BOD Review Only

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

For 20200402 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Approval of CalOptima Medi-Cal Directed Payments Policy and Modifications to Claims Administrations Policies and Procedures

Contact

Belinda Abeyta, Executive Director, Operations (714) 246-8400
Ladan Khamseh, Chief Operations Officer, (714) 246-8400

Recommended Actions

1. Approve CalOptima Medi-Cal Policy FF.2012: *Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services* to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance;

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2012;

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2012; and

4. Approve modifications of the following Claims Administration Policies and Procedures:
   A. FF. 1002: CalOptima Medi-Cal Fee Schedule
   B. FF. 1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima staff has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and ground emergency medical transportation (GEMT). On June 7,

2018, the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily-mandated rate increase for GEMT. While staff initially planned for these initial Directed Payment initiatives to be time limited, additional Directed Payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends adoption of Medi-Cal policy FF.2012: *Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services*, which has been drafted to address the above-listed qualifying services. This new policy defines Directed Payments and establishes requirements pursuant to which CalOptima will administer Directed Payments for qualifying services rendered to CalOptima Direct and shared risk group members. For shared risk group members, the policy will only apply to Directed Payments for GEMT services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR). CalOptima will follow DHCS guidelines, including APLs or as specified by DHCS through other correspondence, regarding qualifying services, eligible providers, and payment requirements for applicable DOS. Staff anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are established by DHCS or when DHCS subsequently changes existing Directed Payment program requirements, rates, and/or codes.

Staff seeks authority to amend, as necessary and appropriate, CalOptima Medi-Cal Fee-For-Service Physician Contracts and Shared Risk Group Contracts, to reflect that Directed Payments will be made pursuant to CalOptima Policy and Procedures.

Staff also seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2012 before funding is received from DHCS. For certain Directed Payments, such as the new Proposition 56 program for developmental screening services, DHCS expected managed care health plans, including CalOptima, to make Directed Payments for dates of service on or after January 1, 2020 before receipt of funding from DHCS. DHCS final APL for developmental screening services was released in December 2019, however, CalOptima did not receive funding from DHCS until April 2020. Further, per the APL, DHCS intends to renew the directed payment arrangement on an annual basis for the duration of the program. Considering that APLs for subsequent years might include changes in rates or codes, staff believes issuance of Directed Payments prior to CalOptima's receipt of funding from DHCS is appropriate when subsequent final APLs are issued.

Periodically, CalOptima establishes new or modifies existing Policies and Procedures to implement new or modified laws, regulatory guidance, contracts, business practices and benefits. CalOptima has an annual policy review process by which Policies and Procedures are updated and implemented to comply with new laws, regulations, guidelines or programs as required. The following current Policies and Procedures have been impacted and staff is recommending approval of proposed updates:

1. ***FF.1002: CalOptima Medi-Cal Fee Schedule*** outlines the process by which CalOptima establishes and maintains the CalOptima Medi-Cal Fee Schedule for covered services for which CalOptima is financially responsible, in accordance with the DOFR. CalOptima staff proposes revisions to the policy pursuant to the CalOptima annual review process to address DHCS FFS reimbursement rates based on prospective and retroactive rate revisions as referenced in the published DHCS APLs, Medi-Cal Bulletins and NewsFlash when DHCS provides sufficient information to implement the rate revisions, including the effective date, reimbursement rate, current procedural terminology, CPT codes and any modifiers, as necessary. CalOptima shall implement FFS reimbursement rates received via published DHCS APLs, Medi-Cal Bulletins and NewsFlash to the extent the FFS reimbursement rate is not reflected in the Medi-Cal Fee Schedule. Proposed revisions also include basing DHCS FFS reimbursement rates on expected rates referenced in the pending State Plan Amendment filed with CMS for Proposition 56 directed payments if instructed in writing by DHCS and removing Operating Instruction Letters as a source for rate changes. Additional proposed changes are intended to include contracted providers' right to file a complaint, as well as updating definitions and several grammatical changes.

2. ***FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group*** outlines CalOptima's payment methodologies for a provider or practitioner that provides covered services to a member of CalOptima Direct or a member enrolled in a shared risk group. For those members enrolled in a shared risk group, The policy only applies to covered services for which CalOptima is financially responsible, in accordance with the DOFR. Revisions to the policy are being proposed pursuant to the CalOptima annual review process to address directed payments under policy FF.2012, licensed midwives services, and reimbursement for a 12-month supply of FDA-approved, self-administered hormonal contraceptives under specified circumstances. Proposed revisions also include the addition of language requiring a health network that authorizes an inpatient admission to retain financial responsibility for the entire stay notwithstanding a member's change in health network. Additional proposed updates include adding and updating definitions, as well as minor grammatical changes.

Fiscal Impact

The recommended action to approve CalOptima Policy FF.2012 and implement the other recommended change are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment program. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

The recommended action to revise CalOptima Policies FF.1002 and FF.1003 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget pending Board approval.

Rationale for Recommendation

The recommended action will ensure that CalOptima continues to be compliant with regulatory guidance provided by DHCS.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachments

1. Entities Covered by this Recommended Board Action
2. FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services
3. FF.1002: CalOptima Medi-Cal Fee Schedule
4. FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
5. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
6. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
7. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Richard Sanchez — *05/27/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates	10855 Business Center Dr Ste. C	Cypress	CA	90630
Talbert Medical Group	2175 Park Place	El Segundo	CA	90245
Arta Western Medical Group	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
Alta Med Health Services Shared Risk	2040 Camfield Ave	Los Angeles	CA	90040

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Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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3. The Designated Provider was eligible to receive the Directed Payment.

4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

E. CalOptima shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

F. CalOptima shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. For CalOptima Direct, how to file a grievance and second level appeal with CalOptima. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima.

H. CalOptima Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint and/or FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, as applicable.

III. PROCEDURE

A. Directed Payments for Qualifying Services

For 20201604 BOD Review Only

1. Physician Services: For dates of service on or after July 1, 2017, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            a) On or before the first birthday;

            b) After the first birthday and before or on the second birthday; or

            c) After the second birthday and on or before the third birthday.

        ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings.

    b. Development Screening Services are not subject to any Prior Authorization requirements.

    c. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

    d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

        i. The tool that was used to perform the Developmental Screening Service;

        ii. That the completed screen was reviewed;

        iii. The interpretation of results;

        iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

        v. Any appropriate actions taken.

    e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima and/or DHCS upon request.

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f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

      ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

      iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

   b. CalOptima shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

      i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

      ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

   c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

      i. The tool that was used to perform the ACEs Screening Service;

      ii. That the completed screen was reviewed;

      iii. The interpretation of results;

      iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

      v. Any appropriate actions taken.

   d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2017, CalOptima shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

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a. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

5. GEMT Services: For dates of service on or after July 1, 2018, CalOptima shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. CalOptima shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

b. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by CalOptima with specified dates of service (i.e., between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), CalOptima shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, CalOptima shall ensure subsequent Directed Payments required by this Policy are made within ninety (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 CalOptima no later than one (1) year from the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

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3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima shall:

    a. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

    b. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Provider, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

1. CalOptima shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Policy FF.2011: Directed Payments, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by DHCS, including an attestation confirming the completion of the report. Reports shall include CalOptima's Health Care Plan Code, as well as CPT, HCPCS, or Procedure Code, service

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month, payer (e.g., CalOptima or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

a. CalOptima shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima must submit an attestation to DHCS stating that no updated information is available.

b. If updated information is available for the quarterly report, CalOptima must submit the updated quarterly report in the appropriate file format and include an attestation that CalOptima considers the report complete.

2. CalOptima shall continue to submit encounter data for the Directed Payments as required by DHCS.

IV. ATTACHMENTS

A. Directed Payments Rates and Codes

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1000: Medi-Cal Glossary of Terms
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
F. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
G. CalOptima Policy FF.2003: Coordination of Benefits
H. CalOptima Policy FF.2011: Directed Payments
I. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
J. CalOptima Policy GG.1116: Pediatric Preventive Services
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
M. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
N. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
P. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
T. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
U. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services

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V. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective				

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS 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.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Centers for Medicaid and Medicare Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
Centers for Medicaid and Medicare Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare and Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.

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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 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 notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.

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Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Federally Qualified Health Center (FQHC)	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.
Ground Emergency Medical Transport (GEMT) Services	For purposes of this Policy, specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
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.

For 20200604 BOD Review Only

Term	Definition
Medically Necessary or Medical Necessity	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. For Medi-Cal Members receiving managed long term services and support (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code Section 14132(v).
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to CalOptima Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

For 20200604 BOD Review Only

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

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Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[3]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[3]Payment obligations for rates of at least $29 for eligible service codes

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

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Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[4]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[4]Payment obligations for rates of at least $400 and $700 for eligible service codes

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

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Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[6]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[6]*Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

For 20200604 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

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Policy: FF.1002
Title: **CalOptima Medi-Cal Fee Schedule**
Department: Coding Initiatives
Section: Not Applicable

CEO Approval:

Effective Date: 10/01/2006
Revised Date: TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy defines the process by which CalOptima shall establish and maintain the CalOptima Medi-Cal Fee Schedule.

II. POLICY

A. CalOptima shall maintain a Medi-Cal Fee Schedule to determine payments to Providers and Practitioners, as applicable.

III. PROCEDURE

A. The Department of Health Care Services (DHCS) provides a complete file of the Medi-Cal Fee-for-Service (FFS) Fee Schedule to the public on a monthly basis.

B. Effective April 1, 2011, CalOptima shall update the CalOptima Medi-Cal Fee Schedule on a monthly basis based on the monthly file released by DHCS used to update the Medi-Cal Fee-for-Service (FFS) Fee Schedule.

1. Monthly updates to the CalOptima Medi-Cal Fee Schedule shall be effective the first day of the month following CalOptima's receipt of the monthly file released by DHCS.

C. DHCS provides rates for Child Health and Disability Prevention (CHDP) services and medical and incontinence supplies to the public through the Medi-Cal Provider Manuals. DHCS updates the manuals based on subsequent rate changes.

~~2.~~1. For dates of service on or after July 1, 2018, rates for CHDP will be included in the Medi-Cal Fee-for-Service (FFS) Fee Schedule rather than in the Provider Manuals.

~~C.~~D. The CalOptima Medi-Cal Fee Schedule is based on the following:

1. DHCS FFS reimbursement rates as included in the Medi-Cal Fee-for-Service (FFS) Fee Schedule;

2. DHCS FFS reimbursement rates as referenced in the Medi-Cal Provider Manual for medical and incontinence supplies; and

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3. DHCS FFS reimbursement rates based on prospective and retroactive rate revisions ~~issued by~~as referenced in the published DHCS ~~through Operating Instruction~~ All Plan Letters ~~(OILs).~~, Medi-Cal Bulletins and NewsFlash when DHCS provides sufficient information to implement the rate revisions, including the effective date, reimbursement rate, healthcare common procedure coding system (HCPCS) codes, current procedural terminology (CPT) codes and any modifiers, as necessary. CalOptima shall implement FFS reimbursement rates received via ~~OILs~~published DHCS All Plan Letters, Medi-Cal Bulletins and NewsFlash to the extent the FFS reimbursement rate is not reflected in the Medi-Cal Fee Schedule~~, unless such OIL is related to a~~; and

~~3.~~4. DHCS FFS reimbursement rates are based on expected rates as referenced in the pending State Plan Amendment ~~(SPA) not approved by~~ filed with the Centers for Medicare & Medicaid Services (CMS~~).~~) for Proposition 56 directed payments if instructed, in writing, by DHCS. In the event the expected rates are not approved by CMS, CalOptima shall recoup overpayments and refund underpayments, as applicable, in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

~~D.~~E. CalOptima shall reimburse Providers and Practitioners for Covered Services provided to CalOptima Direct members based on the CalOptima Medi-Cal Fee Schedule in effect on the date the claim is processed for date(s) of service submitted, unless otherwise required by law or contract in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

1. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a non-contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable.

2. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable, as required by law or contract.

~~1.~~3. ~~A non-contracted~~A Provider or Practitioner, whether contracted or non-contracted, shall have the right to file a complaint in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, and HH.1101: CalOptima Provider Complaint.~~.~~

~~2.1. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable, as required by law or contract.~~

~~E.~~F. CalOptima may, in its sole discretion, update the CalOptima Medi-Cal Fee Schedule between the regularly scheduled updates.

~~F.~~G. A Provider and Practitioner shall submit claims for Covered Services rendered to a CalOptima Direct member in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

For 20200604 BOD Review Only

~~G.~~H. The Medi-Cal Fee-for-Service (FFS) Fee Schedule and Provider Manuals are available by accessing the Medi-Cal website.

IV. ATACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Medi-Cal Fee-For-Service Rates: ~~https://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp~~ https://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp
~~G. Medi-Cal Provider Manual: Publications; Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp~~
G. Medi-Cal Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

VI. REGULATORY AGENCY APROVAL(S)

Date	Regulatory Agency
03/14/2011	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2006	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2011	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2016	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/01/2017	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/07/2018	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	05/01/2019	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	TBD	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal

For 20200604 BOD Review Only

IX. GLOSSARY

Term	Definition
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
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.
Covered Service	For purposes of this policy, 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 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), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), 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.
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.
Fee-For-Service Amounts	Amounts adopted by CalOptima for reimbursement to hospitals, physicians and other providers for medical services rendered (other than on a capitated payment basis) to Medi-Cal beneficiaries for which CalOptima is responsible.
Medi-Cal Fee-For-Service (FFS) Fee Schedule	The fee schedule used by the Department of Health Care Services (DHCS) to reimburse Medi-Cal Fee-For-Service Providers.

For 2020/05/04 BOD Review Only

Term	Definition
Medi-Cal Provider Manual	A provider manual created and updated by the Department of Health Care Services as a reference for providers enrolled in the Medi-Cal Fee-for-Service program to include information on Medi-Cal services, programs, claim reimbursement, complete information about recipient eligibility and provider participation, program policies, code lists, claim form and follow-up instructions pertaining to specific provider communities and specialty programs.
~~Operating Instruction Letter~~	~~A letter issued by the Department of Health Care Service to its Fiscal Intermediary for purposes of administering the Medi-Cal Fee-For-Service program.~~
Overpayment	For the purposes of this policy, any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	~~A~~ All contracted Providers including physicians, Non-physician~~, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory~~ Medical Practitioners, ancillary ~~provider, health maintenance organization,~~providers, and facilities or ~~other person or institution that furnishes~~institutions who are licensed to furnish Covered Services.

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For 20200604 BOD Review Only

Policy: FF.1002
Title: **CalOptima Medi-Cal Fee Schedule**
Department: Coding Initiatives
Section: Not Applicable

CEO Approval:

Effective Date: 10/01/2006
Revised Date: TBD

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative

For 20200604 BOD Review Only

I. PURPOSE

This policy defines the process by which CalOptima shall establish and maintain the CalOptima Medi-Cal Fee Schedule.

II. POLICY

A. CalOptima shall maintain a Medi-Cal Fee Schedule to determine payments to Providers and Practitioners, as applicable.

III. PROCEDURE

A. The Department of Health Care Services (DHCS) provides a complete file of the Medi-Cal Fee-for-Service (FFS) Fee Schedule to the public on a monthly basis.

B. Effective April 1, 2011, CalOptima shall update the CalOptima Medi-Cal Fee Schedule on a monthly basis based on the monthly file released by DHCS used to update the Medi-Cal Fee-for-Service (FFS) Fee Schedule.

1. Monthly updates to the CalOptima Medi-Cal Fee Schedule shall be effective the first day of the month following CalOptima's receipt of the monthly file released by DHCS.

C. DHCS provides rates for Child Health and Disability Prevention (CHDP) services and medical and incontinence supplies to the public through the Medi-Cal Provider Manuals. DHCS updates the manuals based on subsequent rate changes.

1. For dates of service on or after July 1, 2018, rates for CHDP will be included in the Medi-Cal Fee-for-Service (FFS) Fee Schedule rather than in the Provider Manuals.

D. The CalOptima Medi-Cal Fee Schedule is based on the following:

1. DHCS FFS reimbursement rates as included in the Medi-Cal Fee-for-Service (FFS) Fee Schedule;

2. DHCS FFS reimbursement rates as referenced in the Medi-Cal Provider Manual for medical and incontinence supplies; and

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3. DHCS FFS reimbursement rates based on prospective and retroactive rate revisions as referenced in the published DHCS All Plan Letters, Medi-Cal Bulletins and NewsFlash when DHCS provides sufficient information to implement the rate revisions, including the effective date, reimbursement rate, healthcare common procedure coding system (HCPCS) codes, current procedural terminology (CPT) codes and any modifiers, as necessary. CalOptima shall implement FFS reimbursement rates received via published DHCS All Plan Letters, Medi-Cal Bulletins and NewsFlash to the extent the FFS reimbursement rate is not reflected in the Medi-Cal Fee Schedule; and

4. DHCS FFS reimbursement rates are based on expected rates as referenced in the pending State Plan Amendment filed with the Centers for Medicare & Medicaid Services (CMS) for Proposition 56 directed payments if instructed, in writing, by DHCS. In the event the expected rates are not approved by CMS, CalOptima shall recoup overpayments and refund underpayments, as applicable, in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

E. CalOptima shall reimburse Providers and Practitioners for Covered Services provided to CalOptima Direct members based on the CalOptima Medi-Cal Fee Schedule in effect on the date the claim is processed for date(s) of service submitted, unless otherwise required by law or contract in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

1. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a non-contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable.

2. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable, as required by law or contract.

3. A Provider or Practitioner, whether contracted or non-contracted, shall have the right to file a complaint in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, and HH.1101: CalOptima Provider Complaint.

F. CalOptima may, in its sole discretion, update the CalOptima Medi-Cal Fee Schedule between the regularly scheduled updates.

G. A Provider and Practitioner shall submit claims for Covered Services rendered to a CalOptima Direct member in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

H. The Medi-Cal Fee-for-Service (FFS) Fee Schedule and Provider Manuals are available by accessing the Medi-Cal website.

IV. ATACHMENT(S)

Not Applicable

For 20200604 BOD Review Only

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Medi-Cal Fee-For-Service Rates: https://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp
G. Medi-Cal Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

VI. REGULATORY AGENCY APROVAL(S)

Date	Regulatory Agency
03/14/2011	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2006	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2011	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2016	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/01/2017	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/07/2018	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	05/01/2019	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	TBD	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal

For 20200604 BOD Review Only

IX. GLOSSARY

Term	Definition
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
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.
Covered Service	For purposes of this policy, 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 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 notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
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.
Fee-For-Service Amounts	Amounts adopted by CalOptima for reimbursement to hospitals, physicians and other providers for medical services rendered (other than on a capitated payment basis) to Medi-Cal beneficiaries for which CalOptima is responsible.
Medi-Cal Fee-For-Service (FFS) Fee Schedule	The fee schedule used by the Department of Health Care Services (DHCS) to reimburse Medi-Cal Fee-For-Service Providers.

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Term	Definition
Medi-Cal Provider Manual	A provider manual created and updated by the Department of Health Care Services as a reference for providers enrolled in the Medi-Cal Fee-for-Service program to include information on Medi-Cal services, programs, claim reimbursement, complete information about recipient eligibility and provider participation, program policies, code lists, claim form and follow-up instructions pertaining to specific provider communities and specialty programs.
Overpayment	For the purposes of this policy, any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who are licensed to furnish Covered Services.

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Policy:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/07
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a ~~Non-Contracted Hospital~~non-contracted hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, ~~shall be~~ in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's ~~prior authorization~~Prior Authorization policies, ~~shall be based on the following~~is as follows:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section

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14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior ~~authorization~~Authorization is required for all non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

e. Border Hospitals: ~~For dates of service after July 1, 2015,~~ CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

4. If a Member changes Health Networks, including CalOptima Direct, for purposes of this provision, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member ~~of CalOptima Direct or a Member enrolled in a Shared Risk Group,~~ as follows:

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1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-~~Contracted~~contracted Practitioner: CalOptima's reimbursement to a ~~Non-Contracted~~non-contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

   a. Emergency Services: CalOptima shall reimburse a ~~Non-Contracted~~non-contracted Practitioner that provides ~~Emergency~~emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

   b. Non-Emergency Services: CalOptima shall reimburse a ~~Non-Contracted~~non-contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

      i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program. ~~.~~

      ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program ~~-~~paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

      iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case ~~no~~ less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

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viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse ~~up thirteen cycles of oral contraceptives,~~ a ~~twelve~~ provider, including a non-contracted provider, for a (12~~))~~-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches ~~(36 patches), and a twelve (12) month supply of~~, or hormone-containing contraceptive vaginal rings ~~(12 rings), if such quantity is~~when dispensed ~~in an onsite clinic and billed~~at one time at a Member's request by a ~~Qualified Family Planning Provider, including a non-contracted Qualified Family Planning Provider, or dispensed by a~~qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife ~~or Certified Nurse Practitioner services~~and licensed midwives services as permitted within each practitioner's scope of practice, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

i. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

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E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

   a. If the American Indian Health Service Program is a Rrural Hhealth Cclinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

   b. If the American Indian Health Service Program is a Rrural Hhealth Cclinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

   c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register-. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

   a. The American Indian Health Service Program provider must be identified by DHCS;

   b. Service must be a Covered Service included in CalOptima's contract with DHCS;

   c. As set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

      i. Medical health visit;

      ii. Mental health visit;

      iii. Ambulatory visit.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an ~~Ancillary Service~~ancillary service Provider for Covered Services rendered to a

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Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted ~~Ancillary Services Provider~~ancillary service provider based on the terms and conditions of the contract between such ~~Contracted Ancillary Service Provider~~contracted ancillary service provider and CalOptima.

2. CalOptima shall reimburse a ~~Non-Contracted Ancillary Services Provider~~non-contracted ancillary service provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Directed Payment: CalOptima shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for which CalOptima is financially responsible, in accordance with the requirements of CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to a Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services.

~~G.~~H. Non-~~Contracted Hospitals, Non-Contracted~~contracted hospitals, non-contracted Practitioners, and ~~Non-Contracted Ancillary Service~~non-contracted ancillary service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

~~H.~~I. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

~~I.~~J. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B. CalOptima Policy AA.1000: Glossary of Terms~~
~~C.~~B. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
C. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group

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D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.2011: Directed Payments
F. CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services
G. CalOptima Policy GG.1116: Pediatric Preventive Services
~~F. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group~~
~~G.~~H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~H.F. CalOptima Policy GG.1116: Pediatric Preventive Services~~
I. CalOptima Policy HH.2022Δ: Record Retention and Access
J. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
K. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
L. ~~Section 1932(b)(2)(D)~~Title 42 of the Code of Federal Regulations, § 422.113(c)(3)
~~L.~~M. Social Security Act, Section 1932(b)(2)(D)
~~M.~~N. California Welfare and Institutions Code~~,§§, ~~, §14105.28 ~~and 14166.245~~
~~N.~~O. California Health and Safety Code, §1797.1
~~O. This policy supersedes:~~
~~P. CalOptima Financial Letter dated August 25, 1995: Fee for service rates~~
~~Q. CalOptima Financial Bulletin #3: Inpatient hospital reimbursement rates under "CalOptima Direct"~~
~~R. CalOptima Financial Bulletin #5: Revised "CalOptima Direct" inpatient hospital rates~~
~~S. CalOptima Financial Bulletin #10: Family planning services~~
~~T. CalOptima Financial Bulletin #17: Additions to CalOptima Direct inpatient hospital rates~~
~~U. CalOptima Financial Bulletin #19: CalOptima Direct rates effective October 1, 1999~~
~~V. CalOptima Financial Bulletin #24: CalOptima Direct rates effective July 1, 2002~~
~~W. CalOptima Financial Bulletin #29: CalOptima Direct rates effective March 1, 2004~~
~~X.~~P. Manual of Current Procedural Terminology (CPT®), American Medical Association~~, Revised 2006~~
~~Y.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
~~Z.~~R. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: ~~-~~Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
~~AA.~~S. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: ~~-~~Hospital Payment for Medi-Cal Post-Stabilization Services
~~BB.~~T. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: ~~-~~Sexually Transmitted Disease Services in Medi-Cal Managed Care
~~CC.~~U. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: ~~-~~Rates ~~For~~for Emergency and Post-Stabilization Acute Inpatient Services Provided ~~By~~by Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
~~DD.~~V. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~16-003(*revised*):~~18-019: Family Planning Services Policy for ~~Contraceptive Supplies~~Self-Administered Hormonal Contraceptives
~~EE.~~W. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~15-017:~~ 18-022: Access Requirements for Freestanding Birth Centers and the Provision of ~~Certified Nurse~~ Midwife ~~and Alternative Birth Center Facility~~ Services ~~(Revised)~~
~~FF.~~X. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~16-016~~19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network ~~"~~Border~~"~~ Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
12/10/2009	Department of Health Care Services (DHCS)
03/10/2014	Department of Health Care Services (DHCS)
07/06/2016	Department of Health Care Services (DHCS)
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/04/2002	Regular Meeting of the CalOptima Board of Directors
06/05/2007	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
06/03/2008	Regular Meeting of the CalOptima Board of Directors
10/02/2008	Regular Meeting of the CalOptima Board of Directors
11/06/2008	Regular Meeting of the CalOptima Board of Directors
11/05/2009	Regular Meeting of the CalOptima Board of Directors
06/06/2013	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/06/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	TBD	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

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IX. GLOSSARY

Term	Definition
American Indian Health Services Program	Programs operated with funds from the IHS 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.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
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.

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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, ~~California Code of Regulations (~~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 Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
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 IUCD 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.

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Term	Definition
Federally Qualified Health Center	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.
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.
~~American Indian Health Services Program~~Medically Necessary or Medical Necessity	~~Programs operated with funds from the IHS 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.~~ 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, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Licensed Midwife, Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.

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Term	Definition
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200. ~~A Physician, Physician Assistant (under the supervision of a Physician), Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medications. Pursuant to California Business and Professions Code section 2725.2, if these contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to Business and Professions Code section 2725.2 and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier TD (TD modifier as used for RN for (Behavioral Health) as found in the Medi-Cal Provider Manual.~~
Rural Health Clinic	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

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Policy:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/07
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a non-contracted hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's Prior Authorization policies, is as follows:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

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b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior Authorization is required for all non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

e. Border Hospitals: CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

4. If a Member changes Health Networks, including CalOptima Direct, for purposes of this provision, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

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2. Non-contracted Practitioner: CalOptima's reimbursement to a non-contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

   a. Emergency Services: CalOptima shall reimburse a non-contracted Practitioner that provides emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

   b. Non-Emergency Services: CalOptima shall reimburse a non-contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

      i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program-paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

      iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

      vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

      viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by

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DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse a provider, including a non-contracted provider, for a (12)-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a Member's request by a qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife and licensed midwives services as permitted within each practitioner's scope of practice, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

i. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

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a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

a. The American Indian Health Service Program provider must be identified by DHCS;

b. Service must be a Covered Service included in CalOptima's contract with DHCS;

c. As set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

i. Medical health visit;

ii. Mental health visit;

iii. Ambulatory visit.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an ancillary service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted ancillary service provider based on the terms and conditions of the contract between such contracted ancillary service provider and CalOptima.

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2. CalOptima shall reimburse a non-contracted ancillary service provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Directed Payment: CalOptima shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for which CalOptima is financially responsible, in accordance with the requirements of CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to a Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services.

H. Non-contracted hospitals, non-contracted Practitioners, and non-contracted ancillary service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

I. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

J. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
C. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.2011: Directed Payments
F. CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services
G. CalOptima Policy GG.1116: Pediatric Preventive Services
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy HH.2022Δ: Record Retention and Access

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J. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
K. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
L. Title 42 of the Code of Federal Regulations, § 422.113(c)(3)
M. Social Security Act, Section 1932(b)(2)(D)
N. California Welfare and Institutions Code, §14105.28
O. California Health and Safety Code, §1797.1
P. Manual of Current Procedural Terminology (CPT®), American Medical Association
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
T. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
U. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-019: Family Planning Services Policy for Self-Administered Hormonal Contraceptives
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
12/10/2009	Department of Health Care Services (DHCS)
03/10/2014	Department of Health Care Services (DHCS)
07/06/2016	Department of Health Care Services (DHCS)
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/04/2002	Regular Meeting of the CalOptima Board of Directors
06/05/2007	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
06/03/2008	Regular Meeting of the CalOptima Board of Directors
10/02/2008	Regular Meeting of the CalOptima Board of Directors
11/06/2008	Regular Meeting of the CalOptima Board of Directors
11/05/2009	Regular Meeting of the CalOptima Board of Directors
06/06/2013	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/06/2019	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	TBD	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

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IX. GLOSSARY

Term	Definition
American Indian Health Services Program	Programs operated with funds from the IHS 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.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
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.

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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, 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 Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
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 IUCD 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.

For 20200604 BOD Review Only

Term	Definition
Federally Qualified Health Center	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.
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.
Medically Necessary or Medical Necessity	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, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Licensed Midwife, Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200.
Rural Health Clinic	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

For 20200604 BOD Preview Only

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

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delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

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increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Finance and Audit Committee

Report Item

7. Consider Recommending Board of Directors' Authorization for the Reallocation of Budgeted but Unspent Salary Dollars to Expand the Scope of Work of a Contract for External Peer Review Services Contract and Extend a Contract for Medical Consulting Services

Contacts

David Ramirez, M.D., Chief Medical Officer, Medical Management, (714) 347-3261
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574
Esther Okajima, Director, Quality Improvement, (714)347-3270

Recommended Actions

Recommend that the Board of Directors:

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with Advanced Medical Reviews (AMR) to expand the scope of work to include the provision of the following services:
    a. Retro claims review to ensure medical services are billed appropriately;
    b. Review of Grievance and Appeal cases to ensure same or similar specialty review;
    c. Review of Behavioral Health cases; and
    d. Review of Fraud, Waste and Abuse cases.
2. Authorize reallocation of budgeted but unused funds to support the expanded scope of services for AMR through June 30, 2021:
    a. Up to $28,000 from Medical Management – Salaries to Medical Management – Professional Fees; and
    b. Up to $52,000 from Medical Management – Salaries to Administrative Expenses – Professional Fees; and
3. Authorize reallocation of budgeted but unused funds of up to $45,000 from Medical Management – Salaries to Medi-Cal Management – Professional Fees and to extend the contract with medical consultant, Peter Scheid, M.D., to assist with Potential Quality Issue (PQI) cases through June 30, 2021.

Background

CalOptima is required to review appeals and potential quality issues in order to maintain compliance with existing regulations and contractual obligations. Additionally, CalOptima must complete reviews within required timeframes in order to maintain compliance. Each month, CalOptima completes on average 140 appeal reviews and 134 PQI reviews. CalOptima currently has a staff of 6 board certified Medical Directors and two Medical Director positions that have been open since June 2018 and January 2019, respectively. CalOptima Medical Directors share 24/7 call coverage and also assist with committee meetings, clinical programs and projects, and quality improvement efforts.

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Since 2012, with CalOptima's pursuit of accreditation, use of board-certified consultants to assist in making medical necessity determinations is a requirement per National Committee for Quality Assurance (NCQA) Utilization Management (UM) Standards. Also, in the case of appeals, the review of an appeal must be conducted with a practitioner who is in the same or similar specialty. Per these standards, CalOptima must have policies and procedures for how board-certified consultants are used and provide evidence of how they are used as part of the decision-making process for denials and appeals.

On February 1, 2014, CalOptima entered into a contract with Advanced Medical Reviews (AMR). Currently, AMR is the only outside entity that provides clinical medical record review services for CalOptima.

With regard to hiring medical consultants, on April 2, 2020, the Board of Directors (the Board) approved reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants to assist with CalOptima's response to the Coronavirus (COVID-19) pandemic (refer to Attachment 1). On April 16, 2020, the Board authorized amendments to contracts with medical consultants and authorized unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020 (refer to Attachment 2). In order to maintain compliance with the required reviews of appeals and PQIs, staff is requesting reallocation of funding from the open Medical Director positions to support continued use of the temporary consultant.

Discussion

External Peer Review

There are many benefits for using External Peer Reviews (EPRs) for clinical medical record review. It can address conflicts of interest by removing bias and assists with regulatory, credentialing and accreditation requirements. Independent review services can also remove barriers for quality improvement efforts, ensure adherence to quality standards and reduce liability risk. Circumstances where a health plan would seek external peer review include, but are not limited to:

1. Litigation;
2. Conflicting recommendations from internal reviewers;
3. Lack of internal resources and expertise;
4. Review by same or similar specialty; and
5. Improving efficiency

Multiple CalOptima departments have business demands that require timely access to independent review services. Currently, Medical Directors leverage EPRs for the review of Potential Quality Issue (PQI) cases when the physician under review is of a specialty outside of the Medical Directors. CalOptima's current Medical Directors are board certified in Family Medicine, Internal Medicine, Psychiatry, Pediatrics and Cardiothoracic Surgery. Cases outside of these specialties are referred for independent review services. UM Medical Directors utilize EPRs to review denial cases as needed. Grievance and Appeals leverage independent review services to review second level appeals,

especially when a reviewer with same or similar specialty is required. Claims utilizes EPRs for coding validation of billed services. For Behavioral Health, only a qualified licensed clinical psychologist or board-certified psychiatrist can review and issue denials for medical necessity or benefit coverage. Access to EPRs with behavioral health specialty is essential in meeting regulatory requirements. Compliance utilizes EPRs to assist with reviewing medical records for potential Fraud, Waste and Abuse (FWA) cases. An effective Compliance Program requires timely investigation to ensure CalOptima can seek overpayment recovery or implement necessary preventive controls.

Management proposes to make a reallocation of budgeted but unused funds of $80,000 from Medical Management – Salaries. Several Medical Management vacant positions remain vacant, thereby making these funds available for reallocation.

- Reallocation of $28,000 from Medical Management – Salaries to Medical Management – Professional Fees: The CalOptima Fiscal Year (FY) 2020-21 Operating Budget includes $80,000 for external peer review services. With an expanded scope of services for AMR, staff projects a budget shortfall of $28,000 through June 30, 2021.

- Reallocation of $52,000 from Medical Management – Salaries to Administrative Expenses – Professional Fees. The forecasted budget shortfall is based on current retroactive claims review utilization with a 10% increase to allow for any unexpected increase in utilization (see Attachment 3 for more details)

Medical Consultant

CalOptima's Medical Management Department requires additional resources in clinical reviews to reduce the workload for the current Medical Directors, especially in PQI cases. Unfortunately, CalOptima staff have been encountering challenges with hiring new Medical Directors. While continuing the efforts to recruit new Medical Directors, in the interim, CalOptima staff recommends extending a contract with the medical consultant, Dr. Peter Scheid, who is familiar with CalOptima's quality standards and internal processes, to provide additional clinical support to ensure our members' quality of care during this difficult time.

Management proposes to make a reallocation of budgeted but unused funds of up to $45,000 from Medical Management – Salaries to Medi-Cal Management – Professional Fees to fund the contract through June 30, 2021.

Fiscal Impact

The fiscal impact for the recommended actions is budget neutral. Unspent budgeted funds from Medical Management – Salaries approved in the CalOptima Fiscal Year 2020-21 Operating Budget on June 4, 2020, will fund the total cost of $125,000 for the recommended actions.

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Rationale for Recommendation

Staff is recommending Board approval to reallocate funds to meet changing business needs and expand options for external peer review to ensure optimal efficiency and timeliness in the clinical medical record review process. Staff also believes that extending the contract with the medical consultant will help reviewing PQI cases and other clinical decisions in a timely manner while maintaining high quality standards.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated April 2, 2020, "Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities"
3. Previous Board Action Dated April 16, 2020, "Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic"
4. AMR Consultants Usage Log

/s/ Richard Sanchez — **Authorized Signature**

11/10/2020 — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Advanced Medical Reviews	PO Box 492345	Redding	CA	96049
Peter J. Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

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Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

For 20200402 BOD Review Only

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

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i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

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2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

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in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

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1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
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 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.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

For 2020 POD Review Only

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	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.
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.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	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. 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 WIC Section 14059.5.
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.

For 2020

Term	Definition
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.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
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.

For 2020040 Preview Only

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

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Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

DRAFT

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

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G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

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a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

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C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

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a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

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I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	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.
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.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	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.

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Term	Definition
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-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
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.

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL.COM
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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 16, 2020
Special Meeting of the CalOptima Board of Directors

Report Item
4. Consider Ratification and Authorization of Expenditures Related to Coronavirus Pandemic

Contact
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Ratify and authorize unbudgeted expenditures from existing reserves for emergency purchases related to the coronavirus pandemic not to exceed $80,327; and

2. Authorize amendments to contracts with medical consultants Tanya Dansky, M.D. and Peter Scheid, M.D., who are assisting with CalOptima's response to the coronavirus pandemic, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $48,000 to fund contract extensions through June 30, 2020.

Background
On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247) 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. Along with other federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

At its April 2, 2020, meeting, the Board ratified unbudgeted expenditures for emergency purchases to support coronavirus mitigation strategies, including CalOptima's Temporary Telework process, in an amount not to exceed $915,000. Under a separate action, the Board also ratified contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., to assist with CalOptima's response to the coronavirus situation, and reallocated budgeted but unused funds of $20,000 from the Professional Fees budget to fund these contracts.

Discussion
Emergency Purchases Related to Coronavirus Pandemic
Staff recommends the Board ratify and authorize unbudgeted expenditures for the following emergency purchases related to the coronavirus pandemic:

Department	Description	Amount
PACE	Staff personal protective equipment	$30,110
	Member personal protective equipment	$4,734
Information Services	Remote printing, mailing for operational areas (i.e., UM, Claims, MLTSS, GARs)	$30,000
Facilities	Staff personal protective equipment	$11,905
	Gloves, disinfectant products	$578

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Department	Description	Amount
	Estimated expenses for disinfectant products through June 30, 2020 ($1,000/month)	$3,000
	Total	**$80,327**

CalOptima contracted with the existing vendors to ensure timely and efficient service, compatibility with existing equipment, and the protection and security of CalOptima's employees and members. Emergency purchases with contracted vendors were completed with an emergency bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Contract Extensions with Medical Consultants

Staff recommends extending contracts with medical consultants, Tanya Dansky, M.D. and Peter Scheid, M.D., through June 30, 2020, in order to continue work related to coronavirus mitigation activities, including information review and dissemination, regulatory reporting, collaboration with state, county and local entities, and other support activities for the Chief Medical Officer, as needed. The additional cost for the contract extensions through June 30, 2020, is $48,000.

Fiscal Impact

The recommended actions to ratify and authorize unbudgeted expenditures related to coronavirus pandemic and extend contracts with medical consultants are unbudgeted items. An allocation of up to $128,327 from existing reserves will fund these actions.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members during the coronavirus pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

/s/ Richard Sanchez — *04/10/2020*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Tanya Dansky, M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid, M.D.	17 Calle Frutas	San Clemente	CA	92673

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

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Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

For 20200402 BOD Review Only

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

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i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

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2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

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in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

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1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
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 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.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

For 2020 POD Review Only

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	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.
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.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	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. 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 WIC Section 14059.5.
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.

For 2020

Term	Definition
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.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
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.

For 2020040 Preview Only

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

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Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

DRAFT

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.*, encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

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G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

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a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

DRAFT

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

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a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

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I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	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.
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.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	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.

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Term	Definition
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-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
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.

DRAFT

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. **Data Architect**

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

E-MAIL PSCHEID12@GMAIL.COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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(949) 229-7684 FAX

EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL.COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

AMR Consultants	FY19-20	FY20-21	14 mo RR	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
Claims	$ 53,781	$ 5,319	$ 4,221		$ 1,379	$ 3,152	$ 4,531	$ 2,758	$ 6,501	$ 5,319	$ 5,319	$ 7,683	$ 5,713	$ 7,683	$ 3,743	$ 1,182	$ 4,137										
FWA	$ 8,393	$ 1,169	$ 683									$ 3,087	$ 775	$ 3,546	$ 985	$ 197	$ 972										
GARS	$ 54,372	$ 20,685	$ 5,361	$ 3,940	$ 2,561	$ 4,728	$ 6,304	$ 2,955	$ 7,880	$ 1,970	$ 6,698	$ 3,349	$ 5,122		$ 8,865	$ 9,850	$ 10,835										
Pharmacy	$ 1,773	$ -	$ 127	$ 197						$ 197		$ 197	$ 197		$ 985												
PQI	$ 7,513	$ 1,182	$ 621	$ 394	$ 486	$ 381	$ 1,773	$ 1,366	$ 486	$ 788	$ 1,445	$ 197			$ 197	$ 394	$ 788										
UM	$ 16,115	$ 5,132	$ 1,518	$ 92	$ 394	$ 197	$ 985	$ 985	$ 3,349	$ 3,546	$ 473	$ 1,366	$ 1,576	$ 1,379	$ 1,773	$ 3,047	$ 2,085										
Total	**$ 141,947**	**$ 33,487**	$ 12,531	**$ 4,623**	**$ 4,820**	**$ 8,458**	**$ 13,593**	**$ 8,064**	**$ 18,216**	**$ 11,820**	**$ 13,935**	**$ 15,879**	**$ 13,383**	**$ 12,608**	**$ 16,548**	**$ 14,670**	**$ 18,817**										

Medical Consultant Services	FY19-20	FY20-21	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
Tanya Dansky, MD	$ 10,500	$ -										$ 5,250	$ 5,250													
Peter Scheid, MD	$ 20,700	$ 10,050									$ 4,200	$ 4,200	$ 4,800	$ 7,500	$ 4,950	$ 5,100										
Total	**$ 31,200**	**$ 10,050**									**$ 4,200**	**$ 9,450**	**$ 10,050**	**$ 7,500**	**$ 4,950**	**$ 5,100**										

Budget	**Monthly Est'**
818-020 Budget	$ 6,667
Medical Directory Salary .5 FTE	$ 9,265
Total	$ 15,931
Run Rate 2020 CY	**Monthly Est'**
AMR with Claims/GARS:	$ 14,708
AMR with GARS, no Claims:	$ 9,610
AMR without Claims/GARS:	$ 3,774
Medical Consultant 10hr/Wk*$300/hr	$ 13,500

Existing Budget 818-020	80000
Run Rate * 10 months	125310
July/August invoice	34000
Claims Fund Request	52000
Amt needed in 818-020	27310

Row Labels	Count of Referring Dept
2019	**436**
Claims	106
GARS	216
Pharmacy	5
PQI	62
UM	47
2020	**480**
Claims	195
FWA	31
GARS	168
Pharmacy	8
PQI	16
UM	62
Grand Total	**916**

Row Labels	Count of Refer	Sum of Amount Billed
2019	**421**	**$ 64,669.00**
Claims	106	$ 20,882.00
GARS	213	$ 31,126.00
Pharmacy	5	$ 394.00
PQI	56	$ 5,477.00
UM	41	$ 6,790.00
2020	**487**	**$ 93,524.00**
Claims	195	$ 38,415.00
FWA	31	$ 4,847.00
GARS	173	$ 34,081.00
Pharmacy	8	$ 1,576.00
PQI	16	$ 2,627.00
UM	64	$ 11,978.00
Grand Total	**908**	**$ 158,193.00**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Finance and Audit Committee

Report Item

8. Consider Recommending Board of Directors' Approval of Actions Authorizing Extensions and Other Modifications of Whole Person Care Agreements with the Orange County Health Care Agency

Contacts

Candice Gomez, Executive Director Program Implementation, (714) 246-8849
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Recommend that the Board of Directors, contingent on extension of the Whole Person Care (WPC) pilot in the Medi-Cal 2020 Waiver authorize the Chief Executive Officer (CEO), with assistance of legal counsel, to extend and amend the following agreements with the Orange County Health Care Agency (OCHCA) consistent with the WPC extension(s) granted:

1. WPC Administrative Services Agreement; and
2. WPC Grant Agreement for Recuperative Care Services

Background

On October 24, 2016 the County of Orange (County) received approval from the Department of Health Care Services (DHCS) for a five-year program to implement the WPC. Administered by the OCHCA, WPC takes a patient-centered approach to coordinate physical, behavioral health, and social services with the overall goal to improve the health and well-being of Medi-Cal members experiencing homelessness. Recuperative Care is a key service provided under the County's WPC pilot, providing supportive care following discharge from an emergency room, inpatient hospitalization, or skilled nursing facility to Medi-Cal beneficiaries experiencing homelessness and meeting criteria. Recuperative care is also initiated based on direct referrals from clinics, public health nurses, and outreach and engagement staff.

The current WPC is set to expire on December 31, 2020. DHCS has requested CMS approval of a one year extension of the Medi-Cal 2020 wavier, including WPC pilots, through December 31, 2021; this includes a request for additional funding for WPC. While it is expected that the WPC will continue, final determination on the extension and, if approved, any details may not be known by the end of the year. WPC may be extended on a month-to-month basis until final determination is made. Should the federal extension not be granted, OCHCA will be able to support ongoing administration and wind-down of WPC, including recuperative care, until April 1, 2021.

CalOptima has participated in the WPC since its inception and has executed two separate agreements with OCHCA for administrative services and a recuperative care grant. Both agreements currently expire on December 31, 2020.

Administrative Services Agreement

On June 1, 2017 the Board approved an Administrative Services agreement with OCHCA for participation in the pilot. Pursuant to the DHCS-approved budget and Administrative Services

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Agreement, CalOptima received $100,000 per pilot year towards:

- Administrative support:
  - Physical space for meetings, as well as information systems and project management support for the workgroups;
  - Baseline data to facilitate goal setting and program development; and
  - Data sharing about beneficiaries for better coordination of care, subject to applicable privacy laws, as well as HEDIS data to demonstrate improved outcomes for homeless such as decreased ED visits and hospitalization, as well as increased utilization for prescription, professional and preventative services.
- Coordination support:
  - A WPC Personal Care Coordinator (PCC) to help homeless WPC beneficiaries and organizations supporting them, to navigate CalOptima, health networks and provider.

CalOptima staff time for the project management, data sharing, PCC support and other WPC related activities are allocated against the $100,000 annual payment based on employee related costs accounts in the fiscal year in which it is received. The final $100,000 annual payment was received in August 2020 and allocated towards fiscal year 2020-21.

Recuperative Care Grant Agreement

In 2015, CalOptima implemented a recuperative care pilot using Intergovernmental Funds Transfers (IGT) funds. In total, $1 million from IGT 2 and IGT 3 was allocated towards recuperative care that was initially provided by participating contracted hospitals. On September 7, 2017, the Board authorized CalOptima to end its recuperative care hospital agreements and redirect the remaining IGT funds to OCHCA's WPC recuperative care program. Reimbursement for recuperative care was provided with a cap of $150 per day for up to 15 days following a referral from an emergency room or inpatient discharge.

On August 2, 2018, the Board approved an additional grant of $10 million from IGT 6 and 7, subject to availability of IGT funds. Along with the additional funding, the Board removed the daily funding cap and authorized a 50/50 cost split between the County and CalOptima for up to 90 days. Subsequently, in separate Board actions on December 5, 2019 and June 4, 2020, $2.75 million of the original $10 million CalOptima grant was reallocated towards medical respite ($250,000) and housing supportive services ($2.5 million). Remaining CalOptima grant funding was initially expected to be exhausted concurrent with implementation of recuperative care services as a covered Medi-Cal in-lieu of service benefit on January 1, 2021, as proposed under the state's CalAIM initiative. That initiative, however, has been postponed indefinitely due to the COVID-19 pandemic.

The $2.5 million initially allocated for housing supportive services was reallocated for the Homekey Program by the Board at the request of the County on November 5, 2020. Approximately $3 million of the total $7.25 million of recuperative care allocation has been paid for services through December 2019. The County has advised CalOptima that approximately $1.5 million was accrued through June 2020 and, as of October 15, 2020 remains unbilled. Based on current recuperative care utilization, funding may be adequate to continue until July 2021. However, if the allocated CalOptima funding became the sole funding source, it could be exhausted by April 2021. Because the agreement between CalOptima and the County automatically terminates if the agreement between the County and DHCS for the WPC pilot ends, CalOptima and the County would have to enter into a new contract for the IGT

funds to continue to be used for recuperative care administered by the County if the Whole Person Care pilot is not extended beyond December 31, 2020.

Discussion

The current WPC is set to expire on December 31, 2020. DHCS has requested federal approval for a 1-year extension of the WPC pilots, through December 31, 2021. This includes a request for additional funding for WPC. Final determination on the extension and, if approved, any details regarding funding may not be known by the end of the year. Additionally, while the OCHCA has indicated an interest in continued participation, it is unknown whether local match funding will be available to support continued participation in the WPC pilot after December 31, 2020. Consequently, OCHCA has advised that funding after December 31, 2020 is not expected to be at the same level and expects to focus on critical components of the pilot, which include housing navigation and sustainability services, recuperative care, and the WPC Connect data sharing platform.

OCHCA and CalOptima staff have discussed potential extension and modifications of the administrative services and recuperative care grant agreements to address contingencies including WPC termination at the end 2020, extension through 2021 and operational modifications. As a result, CalOptima staff recommends the following modifications to the current agreements if the Medi-Cal 2020 waiver and the WPC Pilot contract between DHCS and the County are extended.

Administrative Services Agreement

- Extend agreement consistent with any extension(s) to the Medi-Cal 2020 waiver and the WPC Pilot Contract between DHCS and the County;
- Extend administrative support consistent with any extension(s) to the Medi-Cal 2020 waiver and the WPC Pilot Contract between DHCS and the County or until funding to support such services are exhausted, whichever is earlier;
- Modify data sharing provision, subject to applicable privacy laws, to allow for continued data sharing for up to six (6) months following the local WPC pilot termination date to support trailing activities and member transitions to other programs; and
- Extend coordination support of a WPC Personal Care Coordinator through December 31, 2021 or until funding to support such services are exhausted, whichever is earlier.

Recuperative Care Grant Agreement

- Extend agreement consistent with any extension(s) to the Medi-Cal 2020 waiver and the WPC Pilot Contract between DHCS and the County or until IGT funding allocated for the recuperative care grant has been exhausted or WPC administration of recuperative care services are terminated; and
- Include contingency that should the WPC lose funding for the 50/50 cost split for recuperative care services, CalOptima continues reimbursement under the current terms and conditions, except increasing the CalOptima share to one hundred percent (100%), subject to IGT allocated funds availability.

County and CalOptima staff are collaborating on potential modification of criteria to support reimbursement for a longer time period. Additionally, CalOptima and County staff are collaborating to develop a business case for recuperative care as an in-lieu service, if eventually available under

CalAIM or other opportunity. CalOptima staff will return to the Board with further recommendations prior to making any request to DHCS for approval of recuperative care as an in-lieu service.

Fiscal Impact

The recommended action to extend and amend the WPC Administrative Services Agreement is budget neutral. Management has received $100,000 per pilot year to support PCC salary and benefits and enhancements to CalOptima's case management system. Only currently budgeted positions will be used to support the requirements of the WPC program, with no additional fiscal impact.

The recommended action to extend and amend the WPC Grant Agreement for Recuperative Care Services has no fiscal impact to CalOptima's operating budget. Payments for recuperative care services provided under the recommended actions are contingent upon the availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

CalOptima has a long-standing relationship with the OCHCA. Both organizations share common goals of improving access to care and health care outcomes for vulnerable residents of Orange County. The WPC Pilot provides an opportunity to integrate systems of care and reduce inappropriate emergency department and inpatient utilization for CalOptima members experiencing homelessness.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by This Recommended Board Action
2. Board Action dated June 1, 2017, Consider Authorizing Contracts with the Orange County Health Care Agency (OCHCA) and Other Participating Organizations for the Whole Person Care (WPC) Pilot
3. Board Action dated December 5, 2019, Consider Authorizing Reallocation of Intergovernmental Transfer Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or contract Amendment(s) with the County of Orange for Implementation, including as attachments Board Action dated September 7, 2017 Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members and Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7
4. Board Action dated June 4, 2020, Consider Authorizing a Grant Agreement with the County of Orange for Medical Respite Care

/s/ Richard Sanchez — *11/10/2020*

Authorized Signature — **Date**

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Attachment to the November 19, 2020 Finance and Audit Committee Meeting – Agenda Item 8

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
County of Orange	405 W 5th Street, Suite 756	Sana Ana	CA	92701

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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

38. Consider Authorizing Contracts with the Orange County Health Care Agency (OCHCA) and Other Participating Organizations for the Whole Person Care (WPC) Pilot

Contact

Candice Gomez, Executive Director Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with assistance of legal counsel, to contract with the Orange County Health Care Agency (OCHCA) for the Whole Person Care (WPC) pilot; and
2. Authorize the CEO, with assistance of legal counsel, to enter into information sharing agreements with other organizations participating in the Whole Person Care (WPC) pilot, subject to compliance with all applicable State and Federal privacy laws.

Background

On December 30, 2015 California's Department of Health Care Services (DHCS) received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015 to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

OCHCA collaborated with CalOptima, additional county agencies, hospitals, community clinics, community-based organizations and others to design and submit an application to DHCS for WPC in Orange County. Orange County's WPC pilot focuses on developing infrastructure and integrating systems of care during the first two years and enhanced services in subsequent years. The Pilot will target high utilizing Medi-Cal beneficiaries who are homeless members and those living with mental illness who are homeless or at risk of homelessness. OCHCA will used redirected funding and matching federal funds to implement Orange County's WPC pilot.

One of the DHCS requirements of the WPC Pilot application was for the county to include a letter of participation from the Medi-Cal managed care plan. On June 2, 2016, the CalOptima Board of Directors authorized CalOptima's participation with OCHCA in the WPC pilot program, including providing the OCHCA a letter of participation for the program.

OCHCA submitted its WPC pilot application to DHCS on July 1, 2016. CalOptima's commitment letter dated June 29, 2016 was included with OCHCA's application. DHCS approved OCHCA's initial application in October, 2016 for a total of $23.5 million over five

years. After allocating funds for the initial approved applications, DHCS solicited additional applications for the remaining funds available through the Waiver. On March 1, 2017, OCHCA submitted a supplemental application. DHCS is expected to announce awards for the supplemental applications on June 2, 2017. If approved, the total WPC pilot funding for Orange County would be $33,125,000. DHCS recently advised that contracts for WPC pilots must be executed by July 1, 2017.

Discussion

OCHCA's initial application was approved by DHCS in October 2016. Under the approved application and CalOptima's contract with OCHCA, CalOptima will receive $100,000 per year for 4 years to provide:

- Administrative support:
  - Physical space for meetings, as well as information systems and project management support for the workgroups;
  - Baseline data to facilitate goal setting and program development;
  - Data sharing about beneficiaries for better coordination of care, subject to applicable privacy laws, as well as HEDIS data to demonstrate improved outcomes for homeless, such as decreased ED visits and hospitalization, as well as increased utilization for prescription, professional and preventative services.
- Coordination support:
  - A WPC Personal Care Coordinator (PCC) to help homeless WPC beneficiaries and organizations supporting them, to navigate CalOptima, health networks and provider.

If OCHCA's supplemental application submitted on March 1, 2017 is approved on June 2, 2017, CalOptima will receive an additional $409,200 for CalOptima's case management system enhancements to support bi-directional communication and care plan sharing.

To participate in WPC, CalOptima is required to enter an agreement with OCHCA. Additionally, and in compliance with all applicable State and Federal privacy laws, CalOptima anticipates entering into agreements with various entities participating in the WPC to support information sharing (e.g., contracts including Business Associate Agreements). These participating entities include, for example, OCHCA's vendor providing the platform for bi-directional information sharing, recuperative care providers, and community-based organizations providing services to beneficiaries who are homeless, at risk of homelessness and/or having mental illness.

Fiscal Impact

The fiscal impact of the recommended action to authorize contracts with the OCHCA and other participating organizations for the WPC pilot is expected to be budget neutral. Management anticipates receiving up to $809,200 over the four year period of the proposed WPC pilot to support PCC salary and benefits and enhancements to CalOptima's case management system. Only currently budgeted positions will be used to support the requirements of the WPC pilot's implementation, with no additional fiscal impact anticipated.

Rationale for Recommendation

CalOptima has a long-standing relationship with the Orange County Health Care Agency. The two entities share common goals of improving access to care and health care outcomes for vulnerable residents of Orange County. The WPC Pilot provides an opportunity to integrate systems of care and reduce inappropriate emergency department and inpatient utilization for CalOptima's highest-risk members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated June 2, 2016, Authorize Participation with the Orange County Health Care Agency in the Department of Health Care Services Whole Person Care Pilot Program
2. June 29, 2016 CalOptima Letter of Participation to the Orange County Health Care Agency for Whole Person Care Pilot Program

/s/ Michael Schrader — *5/25/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Authorize Participation with the Orange County Health Care Agency in the Department of Health Care Services (DHCS) Whole Person Care (WPC) Pilot Program

Contact

Cheryl Meronk, Director, Strategic Development, (714) 246-8400
Arif Shaikh, Director, Public Policy and Government Affairs, (714) 246-8400

Recommended Action

Authorize participation with the Orange County Health Care Agency (HCA) in the DHCS WPC Pilot program, including providing the HCA with a letter of participation for the program.

Background

On December 30, 2015 California's Department of Health Care Services (DHCS) received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015 to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. On April 7, 2016, the Orange County Health Care Agency submitted a Letter of Intent (LOI) to DHCS to participate in the WPC Pilot.

Discussion

As per the LOI, the county aims to focus its WPC Pilot on developing infrastructure and integrating systems of care for high utilizing Medi-Cal beneficiaries who access county mental health services, substance use disorder services, and homeless services programs, and also have high instances of emergency room and inpatient utilization. One of the requirements of the DHCS WPC Pilot application is for the county to include a letter of participation from the Medi-Cal managed care plan. The WPC Pilot application must be submitted by July 1, 2016.

CalOptima's participation in the county's WPC Pilot, subject to full compliance with all applicable privacy laws applicable to CalOptima, will focus on the following areas:

- Entering into agreements with the county to share data about beneficiaries for better coordination of care
- Coordination with CalOptima's contracted health networks and providers to identify members who can benefit from WPC Pilot initiatives
- Working with the county and other entities associated with the WPC Pilot to analyze the effectiveness of the program as it relates to emergency department and inpatient utilization trends

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Fiscal Impact

CalOptima does not anticipate incurring material operating expenses related to the recommended action to provide Orange County Health Care Agency with a letter of participation for the DHCS WPC pilot program. As program parameters are finalized, staff will keep the Board updated on the level of staffing resources committed.

Rationale for Recommendation

CalOptima has a long-standing relationship with the Orange County Health Care Agency. The two entities share common goals of improving access to care and health care outcomes for vulnerable residents of Orange County. The WPC Pilot provides an opportunity to integrate systems of care and reduce inappropriate emergency department and inpatient utilization for CalOptima's highest-risk members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Letter of Participation to the Orange County Health Care Agency for WPC
2. Orange County Health Care Agency LOI to DHCS for WPC
3. Whole Person Care (WPC) Pilot Program (DHCS PowerPoint)

/s/ Michael Schrader — *5/26/2016*

Authorized Signature — **Date**

CalOptima
A Public Agency
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June 2, 2016

Mark Refowitz
Director
Orange County Health Care Agency
405 W. 5th Street, 7th Floor
Santa Ana, CA, 92610

Dear Mr. Refowitz:

This letter is to confirm CalOptima's commitment and participation in the Whole Person Care (WPC) Pilot as the Medi-Cal managed care plan for Orange County, subject to full compliance with all applicable privacy laws applicable to CalOptima.

As specified in the WPC application being submitted by the County of Orange as the lead entity, CalOptima is committed to working in partnership with the County in implementing the WPC Pilot. The pilot will focus on developing infrastructure and integrating systems of care for our members who are homeless or at risk of homelessness, and will also specifically target those who are also seriously mentally ill. Additionally, we look forward to the impact of our collaboration with all the participating entities in improving health outcomes for these members.

We are particularly encouraged by the potential of the WPC Pilot to improve data sharing across the participating entities in order to better coordinate care. We believe that certain infrastructure components included in the WPC Application have broader relevance to helping serve all Medi-Cal beneficiaries served by CalOptima and we eagerly await the results of their implementation and evaluation in this pilot opportunity.

Thank you for your role as the lead entity and we look forward to working with you and the other collaborative partners on this program.

Sincerely,

Michael Schrader
Chief Executive Officer

DRAFT

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ochealth CARE AGENCY

OFFICE OF THE DIRECTOR

April 7, 2016

TO: Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services

SUBJECT: **Whole Person Care Pilot Letter of Intent**

Pursuant to instructions dated March 18, 2016, this serves as the Letter of Intent, on behalf of Orange County, for our participation in the Whole Person Care (WPC) pilot. .

Lead Entity Contact Information:

1. Lead Entity Name and Mailing Address is:
   Orange County Health Care Agency, 405 W 5th St, Santa Ana, CA 92701.
2. Point of Contact Name, E-mail Address, and Telephone Number is:
   Melissa Tober, Special Projects Manager, mtober@ochca.com , (714) 834-5891

Preliminary WPC Pilot Design:

1. ***Include a statement about your organization's interest in participating in a WPC pilot.***

   The Orange County Health Care Agency (HCA) is keenly interested in WPC pilot participation based upon our successful collaboration with the DHCS on the Coverage Initiative Program and later the Low Income Health Program. In both of these instances, our collaboration enhanced our working relationship with DHCS, enhanced health care outcomes for vulnerable populations in Orange County, and led to a more efficient transition into Medi-Cal for those populations that are now covered pursuant to the Medi-Cal expansion (MCE) transition.

   HCA believes that through our collaboration on WPC we will, similarly, be able improve outcomes for hard to serve populations, improve care coordination, and increase access to needed social and supportive services through the policies that the DHCS has articulated for WPC.

2. ***Describe the geographic area in which the WPC pilot would operate and the target population(s) for the pilot.***

   - Geographic area: HCA is committed to a collaborative process with local stakeholders about all program parameters relating to WPC. Nonetheless, HCA assumes that the initial geographic focus will be on areas of high Medi-Cal enrollment and high utilization of county mental health, homeless services, and substance use disorder services, and also have high instances of emergency room and inpatient utilization. In Orange County, those areas include primarily Santa Ana, Garden Grove, and Anaheim (with a combined population of over one million people). It is expected, however, that this is an initial focus and during the five-year term of the WPC, other areas of Orange County will be included.

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- Population: Subject to a collaborative process with Orange County partners, HCA believes that WPC will be focused on high utilizing Medi-Cal beneficiaries who access county mental health services, substance use disorder services, and homeless services programs, and also have high instances of emergency room and inpatient utilization.

3. ***List the potential participating entities that would work in partnership with your organization as part of the WPC pilot. Indicate if the entity is a managed care plan, a health services and specialty mental health agency/department, a public agency/department, or a community partner.***

- Orange County Health Care Agency – Lead Entity and also includes:
  - County Behavioral Health (Mental Health and Substance Abuse).
  - County Public Health.
- Orange County Community Resources, which includes:
  - Homeless Prevention Program.
  - Orange County Housing Authority.
  - Veterans Service Office.
- Orange County Social Services Agency.
- CalOptima – the County Organized Health System (COHS) serving Orange County.
- Orange County 211 – A nonprofit offering a comprehensive information and referral system.
- Share Our Selves – A nonprofit FQHC that is also the only community health center in Orange County with a federal designation as a Healthcare for Homeless provider.
- Illumination Foundation – A nonprofit Orange County homeless community provider.
- Others as may be identified during the collaboration process.

4. ***Describe possible interventions and infrastructure that the WPC pilot may implement:***

With respect to infrastructure and data sharing, Orange County is evaluating, with plans to be more definitive in its application:

- Expanding the Homeless Management Information System currently managed by Orange County 211 to include a public health/health module.
- Re-tooling an electronic referral system, previously used for the Low Income Health Program, to link homeless beneficiaries to a care coordination team following an emergency room visit or inpatient admission. This process would happen in real time, allowing the necessary resources to reach the beneficiary when they are at their most vulnerable and have the highest need.
- Establishing/strengthening existing care coordination efforts among the participating entities, through data sharing/coordination.
- Other options as may be raised during the collaborative process, including the local 911 system.

With respect to care not currently reimbursed by Medicaid, Orange County is evaluating, with plans to be more definitive in its application:

- Expansion of recuperative care, a program that provides short- term medical care and care management to homeless persons who are recovering from an acute illness or injury, and whose conditions would be exacerbated by living on the street or in a shelter.
- Establishing medical bridge housing.
- Peer support services, including but not limited to transportation to medical appointments and in-home support services.

- Additional wrap-around and supportive services that not only facilitate a beneficiary's ability to obtain permanent housing, but also allow them to maintain their housing.
- Other options as may be raised during the collaborative process.

5. ***Note whether or not the WPC pilot would provide housing and supportive services to the target population(s):***

   Please see the response to question 4 with respect to supportive services which includes recuperative care and medical bridge housing, as well as wraparound and supportive services to the beneficiary. In addition to supporting the beneficiary to obtain and maintain housing, to the extent that the policies of the WPC Pilot allow, creative solutions to identifying housing options and opportunities will also be explored during the collaboration process. Orange County's rental vacancy rate is 1% to 2%, compared to 4% for California as a whole, placing available rental housing at a premium and causing rents to increase.

Thank you for this opportunity.

Mark A. Refowitz, Director

DG/RS/MAR:mh 16-034

cc: Frank Kim, County Executive Officer
Mark Denny, Chief Operating Officer

Whole Person Care (WPC) Pilot Program

Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services

May 16, 2016

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Presentation Overview

1. WPC Program Overview
2. Key Elements of the WPC Pilots
   - Goals and Strategies
   - Lead and Participating Entities
   - Target Populations
   - Activities/Services
3. Letters of Intent
4. STC Attachments
   - Universal Metrics
   - Variant Metrics
5. Implementation Activities
6. Application Elements and Timeline
7. Questions/Open Discussion

WPC Program Overview

Program Duration

- 5-year program authorized under the Medi-Cal 2020 waiver

Goal

- To test locally-based initiatives that will coordinate physical health, behavioral health, and social services for beneficiaries who are high users of multiple health care systems and have poor outcomes

Funding

- Up to $1.5 billion in federal funds available to match local public funds over 5 years
- Up to $300 million annually is available
- Based on semi-annual reporting of activities/interventions
- Non-federal share provided via Intergovernmental Transfers (IGT)

Goals and Strategies

Increase:

- Integration among county agencies, health plans, providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries
- Coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries
- Access to housing and supportive services

Reduce:

- Inappropriate emergency department and inpatient utilization

Goals and Strategies

Develop:

- An infrastructure that will ensure local collaboration among the entities participating in the WPC pilots over the long term

Improve:

- Health outcomes for the WPC population
- Data collection and sharing among local entities

Achieve:

- Targeted quality and administrative improvement benchmarks

Lead Entities

Lead Entities:

- County
- A city and county
- A health or hospital authority
- A designated public hospital
- A district/municipal public hospital
- A federally recognized tribe
- A tribal health program under a Public Law 93-638 contract with the federal Indian Health Services
- A consortium of any of the above entities

Lead Entity Responsibilities:

- Submits Letter of Intent and application
- Serves as the contact point for DHCS
- Coordinates WPC pilot
- Collaborates with participating entities

Participating Entities

Participating Entities must include at least:

- One (1) Medi-Cal managed care health plan
- One (1) health services agency/department
- One (1) specialty mental health agency/department
- One (1) public agency/department
- Two (2) community partners

Participating Entity Responsibilities:

- Collaborates with the lead entity to design and implement the WPC pilot
- Provides letters of participation
- Contributes to data sharing/reporting

Lead and Participating Entities

- Lead entities indicate in the application who the participating entities will be.
  - DHCS encourages a collaborative approach.
- Only one Medi-Cal managed care plan is required to participate, but DHCS encourages including multiple plans.
  - Medi-Cal managed care plan participation must include the plan's entire network (i.e., where delegation of risk has occurred to an entity in the plan's network).
  - Specific exclusions and exceptions may be considered on a case-by-case basis.
- Lead entities cannot also be one of the two required community partners.

Target Populations

WPC pilots identify high-risk, high-utilizing Medi-Cal beneficiaries in their geographic area.

- Work with participating entities to determine the best target population(s) and areas of need.

Target population(s) may include, but are not limited to, individuals:

- with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
- with two or more chronic conditions;
- with mental health and/or substance use disorders;
- who are currently experiencing homelessness; and/or
- who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g., hospital, skilled nursing facility, rehabilitation facility, jail/prison, etc.).

Letters of Intent

- DHCS released instructions for a Letter of Intent (LOI) in March 2016.
- The purpose of the LOI was to gauge the level of interest, obtain preliminary program design, and provide an opportunity for entities to submit questions
  - Submission of an LOI was voluntary and will not preclude lead entities from applying when the WPC application is released.
- 29 LOIs were received from 28 counties.

Letters of Intent

	Lead Entity	Geographic Area
1	Alameda County Health Care Services Agency	Alameda County, with concentration in the "880 corridor" stretching from Oakland to Hayward
2	Arrowhead Regional Medical Center	San Bernardino County
3	Calaveras County Health and Human Services Agency	Calaveras County
4	California Rural Indian Health Board (CRIHB)	Statewide
5	Contra Costa Health Services	Contra Costa County (Urban areas)
6	County of Imperial Public Health Department	Imperial County (geographic area TBD)
7	County of San Mateo Health System	San Mateo County
8	Humboldt County Department of Health and Human Services	Humboldt County
9	Kern Medical Center	Kern County (Individuals residing within a 15 mile radius of KMC and/or their assigned medical home)
10	Kings County Department of Public Health	Kings County
11	Los Angeles County	Los Angeles County in all 8 county service planning areas
12	Mathiesen Memorial Health Clinic	Calaveras,Tuolumne, and Mariposa Counties
13	Mendocino County Health & Human Services Agency	Mendocino County
14	Monterey County Health Department	Monterey County
15	Orange County Health Care Agency	Orange County with focus on areas of high Medi-Cal enrollment and high utilization of county resources (primarily Santa Ana, Garden Grove, and Anaheim)

Letters of Intent

	Lead Entity	Geographic Area
16	Placer County Health and Human Services	Placer County
17	Riverside University Health System Department of Population Health	Riverside County
18	San Benito County Health and Human Services Agency	San Benito County
19	San Diego County Health and Human Services Agency	San Diego County
20	San Francisco Department of Public Health	City of San Francisco
21	San Joaquin County Health Care Services Agency	San Joaquin County – (initial targets Stockton and Lathrop areas with entire county by demo end)
22	Santa Clara Valley Health and Hospital System	Santa Clara County
23	Shasta County Health and Human Services Agency	Shasta County
24	Solano County Health and Social Services	Solano County
25	Southern Indian Health Council	San Diego County (rural southeast)
26	Tulare County Health and Human Services Agency	Tulare County
27	Ventura County Health Care Agency	Ventura County
28	WellSpace Health	Sacramento
29	Yolo County Health and Human Services Agency	Yolo County

- The list of the lead entities that voluntarily submitted LOIs can also be found at the following link: http://www.dhcs.ca.gov/services/Documents/WPCLOISubmissions.pdf.

Activities/Services

Generally, WPC pilot payments may support activities that:

- **Build infrastructure** to integrate services among local entities that serve the target population.
- **Provide services not otherwise covered or directly reimbursed by Medi-Cal** to improve care for the target population, such as housing components.*
- **Implement strategies** to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

*Federal WPC payments are not available for services provided to non-Medi-Cal beneficiaries.

Activities/Services Examples

- Care coordination
- Recuperative care/medical respite
- Sobering centers
- Transportation
- Field-based care, such as case managers, therapists, or nurses delivering services on the street or in the home
- New IT infrastructure

Activities/Services: Housing Supports & Services

WPC pilots for Housing Supports/Services:

- May target individuals who are experiencing, or are at risk of, homelessness who have a demonstrated medical need for housing or supportive services.
- Must have participating entities that include local housing authorities, local continuum of care program, and community-based organizations serving homeless individuals.

Activities/Services: Housing Supports & Services

Federal Medicaid funds may not be used to cover the cost of:

- Room and board
- Monthly rental or mortgage expense
- Food
- Regular utility charges
- Household appliances or items that are intended for purely diversional/recreational purposes

However, state or local government and community entity contributions that are not used to match WPC pilot federal financial participation (FFP) may be allocated to fund support for long-term housing, including rental housing subsidies.

Activities/Services: Housing Supports & Services

Eligible Housing Supports & Services include:

- Individual Housing Transition Services: housing transition services to assist beneficiaries with obtaining housing, such as individual outreach and assessments.
- Individual Housing & Tenancy Sustaining Services: services to support individuals in maintaining tenancy once housing is secured, such as tenant and landlord education and tenant coaching.
- Additional transition services, such as searching for housing, communicating with landlords, and coordinating moves.

Activities/Services: Housing Supports & Services

Additional transition services:

- Transportation
- Environmental accommodations for accessibility
- Housing transition services beyond case management services that do not constitute room and board, such as:
  - Security deposits
  - Utility set-up fees
  - First month coverage of utilities
  - One-time cleaning prior to occupancy, etc.

Activities/Services: Flexible Housing Pool

The flexible housing pool:

- May include funding created from savings generated by reductions in health, behavioral, and acute care costs, which result from WPC pilot housing-related strategies.
- Can be used to fund additional supports and services that are not available for (FFP), such as rental subsidies, home setup, deposits, and utilities.

STC Attachments

- There are three Special Terms and Conditions (STC) protocols related to Whole Person Care:
  - Attachment GG – Reporting and Evaluation
  - Attachment HH – WPC Pilot Requirements and Application Process
  - Attachment MM – WPC Pilot Requirements and Metrics
- Attachment MM describes the universal and variant metrics that WPC pilots are required to report on.

Universal Metrics

All WPC are required to report on the same set of universal metrics.

- These include four (4) health outcomes measures and three (3) administrative measures.
- **Health Outcomes Measures:**
  - 1. Ambulatory Care
  - 2. Inpatient Utilization
  - 3. Follow-up After Mental Health Illness Hospitalization
  - 4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **Administrative Measures:**
  - 1. Comprehensive Care Plan
  - 2. Care Coordination, Case Management, and Referral Infrastructure
  - 3. Data and Information Sharing Infrastructure

Variant Metrics

Variant metrics are specific to the WPC target population(s), strategies, and interventions.

- Each WPC Pilot must report on a minimum of four (4) variant metrics, including:
  - 1. One administrative metric in addition to the Universal care coordination and data sharing metrics
  - 2. One standard health outcomes metrics (e.g., HEDIS) applicable to the WPC Pilot population across all five program years for each target population
  - 3. WPC Pilots utilizing the PHQ-9 shall report the Depression Remission at Twelve Months (NQF 0710) metric; all other Pilots shall report one alternative health outcomes metric.
  - 4. WPC Pilots including a severely mentally ill (SMI) target population must report on the Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) WPC Pilots; all other Pilots shall report one alternative health outcomes metric.
- WPC Pilots implementing a housing component must report a metric specific to the housing intervention.

Implementation Activities To Date

Completed

- Issued frequently asked questions (FAQs); continually updated as clarifications must be made
- Conducted FAQ webinar
- Released Letter of Intent to gauge level of interest; collected responses
- Released draft application and selection criteria
- Public comment on draft application and selection criteria
- Submitted selection criteria to CMS for approval

Next Steps

- Finalize Attachment MM (metrics protocol) with CMS
- Issue all three protocols (Attachment GG, Attachment HH, and Attachment MM) as final
- Submit valuation outline prior to releasing application
- Release final application and selection criteria
- Conduct application webinar
- Review applications which are due July 1
- Convene a Learning Collaborative

WPC Application Elements

The WPC application must provide information on:

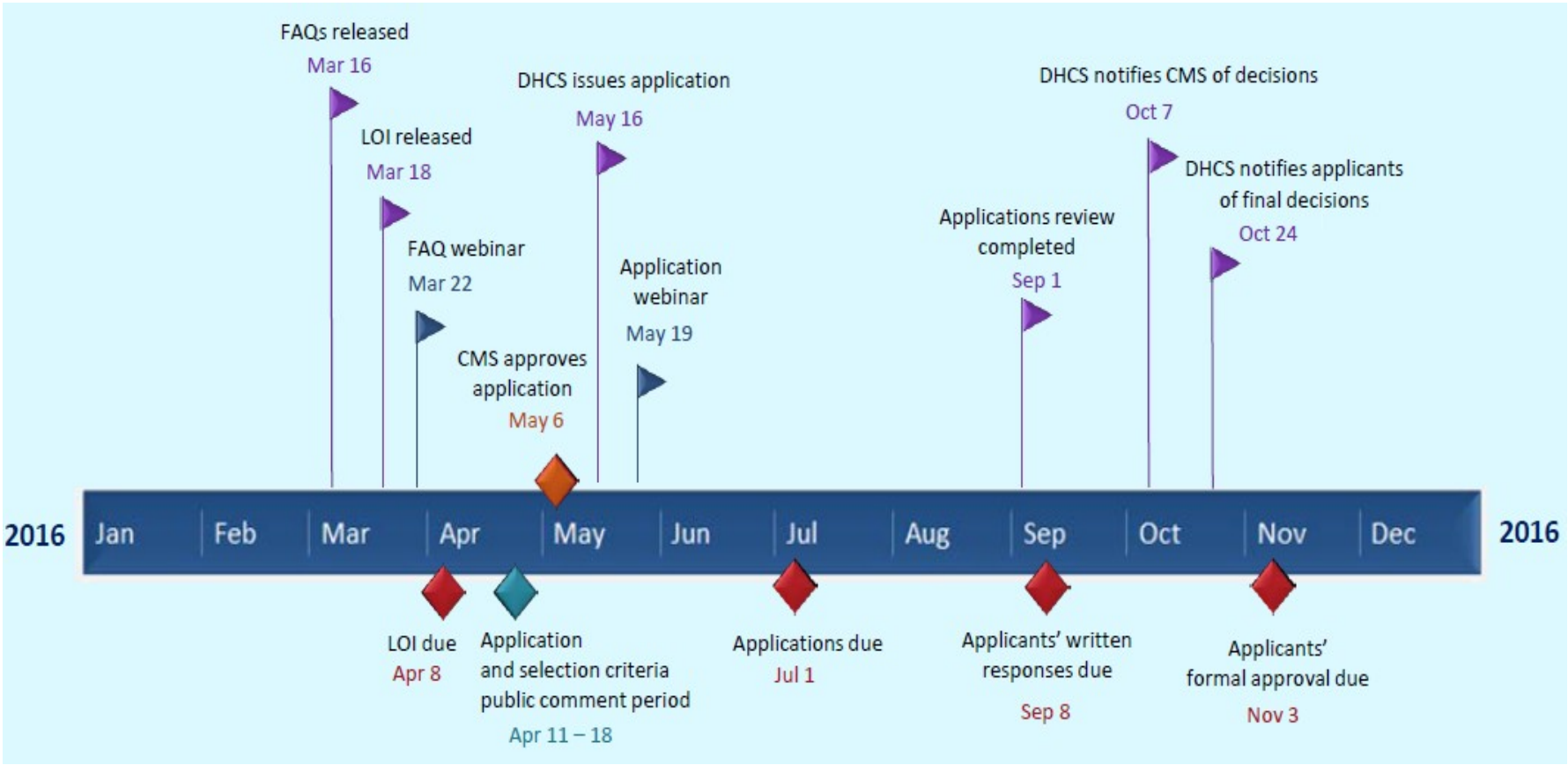
- The target population of the WPC pilot
- Services, interventions, and strategies that will be used for each target population
- How data sharing will occur between the participating entities
- The performance measures the WPC pilot will use to track progress
- The plan for collecting, reporting, and analyzing data
- How monitoring of the participating entities' performance will occur

WPC Application Elements (cont'd)

The WPC application must provide information on:

- The universal and variant metrics that the WPC pilots will report on
- The WPC pilot financing structure, including the funding flow to the lead entity and participating entities
- The total requested funding amount to operate the WPC pilot
- An attestation for the WPC pilot lead entity to participate in learning collaboratives to share best practices among pilot entities

Application Timeline



Resources

Visit our webpage:

- http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

Submit questions/sign up for the listserv:

- 1115WholePersonCare@dhcs.ca.gov

Questions and Discussion



CalOptima
A Public Agency
Better. Together.

June 29, 2016

Sarah Brooks
Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95814

Dear Ms. Brooks:

This letter is to confirm CalOptima's commitment and participation in the Whole Person Care (WPC) Pilot as the Medi-Cal managed care plan for Orange County, subject to full compliance with all applicable privacy laws applicable to CalOptima.

As specified in the WPC application being submitted by the County of Orange as the lead entity, CalOptima is committed to working in partnership with the County in implementing the WPC Pilot. The pilot will focus on developing infrastructure and integrating systems of care for our members who are homeless or at risk of homelessness, and will also specifically target those who are also seriously mentally ill. Additionally, we look forward to the impact of our collaboration with all the participating entities in improving health outcomes for these members.

We are particularly encouraged by the potential of the WPC Pilot to improve data sharing across the participating entities in order to better coordinate care. We believe that certain infrastructure components included in the WPC Application have broader relevance to helping serve all Medi-Cal beneficiaries served by CalOptima and we eagerly await the results of their implementation and evaluation in this pilot opportunity.

We look forward to working with the other collaborative partners on this program.

Sincerely,

Michael Schrader
Chief Executive Officer

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Reallocation of Intergovernmental Transfer Funds Previously Allocated for Recuperative Care to Housing Supportive Services; Consider Authorizing Contract(s) and/or Contract Amendment(s) with the County of Orange for Implementation

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize reallocation of $2.5 million from the $10 million previously allocated IGT 6 and 7 funds of the total of $11 million allocated for recuperative care and medical respite program to housing supportive services for CalOptima Medi-Cal members;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to
    a. Amend CalOptima's current agreement with the County of Orange as necessary to allow for reallocation of funds previously allocated to recuperative care for CalOptima members under the County's Whole Person Care (WPC) Pilot Program; and
    b. Enter into a new agreement or amend CalOptima's current agreement with the County of Orange to include housing supportive services for qualifying CalOptima members.

Background

The WPC Pilot is an Orange County-operated pilot program, administered by the Orange County Health Care Agency (OCHCA), that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. The County of Orange's WPC Pilot application was approved by the Department of Health Care Services (DHCS) in October 2016 and coordinates physical, behavioral health, and social services in a patient-centered approach with the goals of improved and health and well-being through more effective use of resources. The WPC Pilot provides housing supportive services which includes housing navigation and tenancy sustaining services. Additional funding was provided to the WPC Pilot in January 2019 allocating funds specifically to expand existing WPC housing navigation and supportive services for persons living with serious mental illness as well as implement these services for persons who do not have a connection to OCHCA Behavioral Health Services. The WPC Pilot also includes provisions for recuperative care services for up to a maximum of 90 days based on medical need. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to provide enhanced services to CalOptima Medi-Cal members in the following areas: opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the

safety net, children's health, older adult health and other areas as identified by a member health needs assessment.

During the August 2, 2018 CalOptima Board of Directors (Board) meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. While community proposals were solicited, the Board made a grant allocation of up to $10 million from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for CalOptima members experiencing homelessness under the County's WPC Pilot in addition to the $1 million earlier allocated for recuperative care for CalOptima members experiencing homelessness and being discharged from a hospital setting. On April 4, 2019 the Board authorized reallocation of $250,000 from the $10 million IGT 6 and 7 recuperative care fund towards a Medical Respite Program for CalOptima Medi-Cal members meeting medical criteria beyond the 90 days available for recuperative care through the WPC Pilot.

On October 28, 2019 DHCS released the initial CalAIM proposal. While this proposal may be further refined prior to implementation, as proposed, it could significantly impact the future Medi-Cal delivery system. One proposed impact would be for Medi-Cal managed care plans, including CalOptima, to provide recuperative care as an In Lieu of Service potentially beginning as soon January 1, 2021. The County of Orange has determined that of the $9.75 million IGT 6 and 7 funding allocated by the CalOptima Board towards recuperative care, at least $2.5 million dollars can be reallocated toward other services without impacting the availability of recuperative care services for CalOptima members.

Discussion

Housing supportive services encompass housing navigation and sustaining services that include client assessments to identify barriers to housing placement and working with both landlords and members to sustain tenancy. Housing supportive services are incorporated into the member's individualized care plan that integrates all physical, behavioral, and social service needs. This member-centric supportive approach assists the individual to integrate into community-based settings which enhances their ability to be a good neighbor to the rest of the community.

The County of Orange provides housing supportive services to those who quality for the WPC Pilot and/or are linked to the County's Behavioral Health Services Program; however, there continue to be individuals who do not quality for services through these programs. In November 2019, OCHCA established a funding pool which is intended to address funding gaps for those needing but not receiving housing supportive services. In order to support these efforts, CalOptima staff recommends reallocating up to $2.5 million in IGT 6 and 7 funds previously allocated for recuperative care for CalOptima members to housing supportive services for CalOptima members. As proposed, these reallocated IGT 6 and 7 funds would be available to reimburse the OCHCA for housing supportive services provided to CalOptima members receiving services through WPC once WPC funding has been exhausted, or for CalOptima members not receiving services through WPC but in need of housing supportive services. CalOptima members enrolled in the Health Homes Program would be excluded as CalOptima is

coordinating with OCHCA to develop a separate agreement for members enrolled in the Health Homes Program.

The County of Orange contracts with vendors to provide housing supportive services. Services contracted vendors are required to provide, when appropriate, include but are not limited to the following:

- Match WPC clients with a housing voucher to appropriate housing resources or provide navigation services to those who do not have housing vouchers;
- Act as a liaison in collaboration with and between the WPC client and landlord;
- Transport or arrange for transportation of WPC clients to potential housing placement opportunities;
- Assist with the housing application process;
- Secure reasonable letters of support as needed;
- Ensure that the WPC client has a security deposit for housing and utilities;
- Ensure that the WPC client becomes a resident after housing placement;
- Arrange for utilities to be turned on;
- Educate WPC clients on housekeeping issues and "good neighbor" issues such as maintenance, community living, and independent living skills;
- Coach WPC clients in order to have successful interactions when meeting with potential property managers, and prepare them for placement; and
- Link WPC clients to peer mentoring and other sustainability services for ongoing support in an effort to further ensure housing sustainability.

Contracted housing supportive services vendors are approved and reimbursed for six months on a per member per month capitated basis. Individuals are reevaluated every six months and services continue until it is determined that the individual no longer requires housing supportive services. As proposed, CalOptima would reimburse the County for housing supportive services provided to qualifying CalOptima members on a per member per month basis.

Fiscal Impact

The recommended actions to authorize reallocation of up to $2.5 million in IGT 6 and 7 funds to housing supportive services for qualifying CalOptima members has no fiscal impact to CalOptima's Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, collaborates with our provider, community, and county partners to address the healthcare needs of CalOptima members and work to improve the availability, access, and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Board Action
2. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
3. CalOptima Board Action dated April 4, 2019, Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program
4. California Advancing and Innovating Medi-Cal (CalAIM) Executive Summary

/s/ Michael Schrader *11/26/2019*
Authorized Signature **Date**

Attachment to December 5, 2019 Board of Directors Meeting - Agenda Item 14

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
County of Orange	405 W 5th Street, suite 756	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

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

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader — **Authorized Signature**

9/25/2015 — **Date**

CalOptima
A Public Agency
Better. Together.

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements



- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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Attachment to December 5, 2019 Board of Directors Meeting -- Agenda Item 14

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Contacts

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate;
2. Authorize reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program.

Background

The WPC is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to support programs addressing the following areas: Community health investments which may include programs addressing opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by a member health needs assessment. At the August 2, 2018 Board of Directors meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. A grant allocation of up to $10 million was approved from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for homeless CalOptima members under the WPC

pilot. The funds are currently designated for funding 50 percent of medically justified recuperative care bed days up to a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available. The CalOptima Board of Directors also approved an amendment of the agreement with the County of Orange to include indemnity language and allowing for use of the allocated funds for recuperative care services under the County's WPC Pilot program for qualifying homeless CalOptima members.

Discussion

Since 2016, the OCHCA has collaborated with CalOptima and other community-based organizations, community clinics, hospitals, and county agencies to design and implement the WPC Pilot program. The recuperative care element of the WPC pilot is a critical component of the program. During calendar year 2018, the WPC recuperative care program provided services to 487 unique CalOptima members experiencing homelessness. Between August and December 2018, the average length of stay for these individuals was 34 days, at a cost of $705,250.

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy but do not qualify for transition to skilled nursing care, may benefit from medical respite care beyond the 90 days of recuperative care.

To address this concern, CalOptima staff, with the support of OCHCA WPC staff, and consistent with the approved IGT 6/7 funding categories, is proposing to develop a Medical Respite Program for CalOptima members who need extended medical care beyond the 90 days as provided under the current scope of the WPC Pilot to achieve and maintain medical stability. Staff is in the process of developing policies related to the proposed medical respite program, the purpose of which is to provide short-term residential care to allow individuals with unstable living situations the opportunity to rest in a safe and clean environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite care seeks to improve transitional care for the population and to aid in ending the cycle of homelessness while also gaining stability with case management relationships and programs. As appropriate, staff will seek state approval of this new Medical Respite Program, which is intended to support homeless CalOptima members as they recover and attain medical stability, or in the case of members in hospice, to receive services in a stable environment care. The additional time beyond the days available through the County's WPC program is intended to reduce inappropriate and/or avoidable utilization of hospital Emergency Departments, inpatient admissions and re-admissions.

CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis and will need approval by County WPC staff, County Medical Safety Net (MSN) program nurses and CalOptima to be eligible for the Medical Respite Program. Regular reviews and updates will be conducted by the MSN program nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical

stability and steps to move to a skilled nursing facility (SNF), if appropriate. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. CalOptima will monitor utilization and member outcomes.

In addition, staff is seeking authority to reallocate $250,000 out of the $10 million the Board allocated to OCHCA WPC program for recuperative care to fund the Medical Respite Program. In other words, no new funding is being proposed. Instead, the recommendation for authority is to redirect dollars previously committed for recuperative care for homeless CalOptima members in coordination with the County's WPC program. Staff is also seeking authority to provide the OCHCA with reimbursement for the full cost of the Medical Respite Program stay at $120 per day, for all bed days beyond the WPC Pilot recuperative care program, not to exceed the requested reallocation amount of $250,000. The OCHCA supports the recommended actions and plans to continue to invoice CalOptima for members in the Medical Respite Program via a similar process such as the already established invoicing process for recuperative care. The funds will be available through the end of the WPC Pilot or until the funds are exhausted, whichever comes first.

Fiscal Impact
The recommended actions to authorize the creation of a Medical Respite Program for CalOptima members and to authorize a reallocation of $250,000 from the $10 million IGT allocation to Orange County Health Care Agency (OCHCA) for recuperative care services, previously approved by the Board on August 2, 2018, has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
2. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CalOptima Board Action Agenda Referral

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

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

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader — **Authorized Signature**

9/25/2015 — **Date**

CalOptima
A Public Agency
Better. Together.

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements



- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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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
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

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

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

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Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

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California Advancing and Innovating Medi-Cal (CalAIM)
Executive Summary

The Department of Health Care Services (DHCS) has developed a framework for the upcoming waiver renewals that encompasses broader 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, insufficient 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 target social determinants of health and reduce 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 and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on an individual's health and quality of life, and through iterative system transformation, ultimately reduce the per-capita cost 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 initial proposals whose implementation will ultimately depend on whether funding is available.

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, the 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 the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.). As one would expect, 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.

To achieve such outcome, CalAIM proposals offer the solutions to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees. CalAIM seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring 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 to end of life. 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 make system changes necessary to close the gap in transitions between delivery systems, opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles. For the purposes of CalAIM DHCS built off and refined those principles to guide the work we intended to pursue.

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards 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 or 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 plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Key Goals

To achieve such 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 and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The reforms of CalAIM are comprehensive and critical to the success of the delivery system transformation necessary to improve the quality of life for Medi-Cal members as well as long-term cost savings/avoidance that will not be possible to achieve absent these initiatives. Furthermore, these reforms are interdependent and build off one another; without one, the others are not either possible or powerful. Below is an overview of the various proposals and recommendations that make up CalAIM.

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, better health and reduced expenditures in Medi-Cal programs. 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 issues, as well as chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve such goals, DHCS proposes the following recommendations that focus on a whole-person care approach that addresses the needs of our beneficiaries across the board – looking at physical and behavioral as well as social determinants of health, with the overarching goals of improving quality of life and reducing the overall costs for the Medi-Cal population.

- Require plans to submit local population health mangement plans.
- Implement 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, build appropriate enhanced care management and in lieu of services capacity statewide.
- Evaluate participation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
- 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 patient-centered population health 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 include, 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 needs 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 pilots to this new statewide benefit to provide a broader platform to build on positive outcomes from those programs.

Target populations include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;
- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
- Individuals transitioning from incarceration; and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under Whole Person Care, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a managed care plan will integrate into its population health strategy. These services are provided as a substitute, or to avoid, other services such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with Case or 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 needs. Examples of in lieu of services include but are not limited to: housing transition and sustaining services, recuperative care, respite, home and community based wrap around services for beneficiaries to transition or reside safely in their home or community, and sobering centers.

The use of in lieu of services are voluntary, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building an integrated managed long-term services and supports (MLTSS) managed care program by 2026 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 our Medi-Cal managed care plans with financial incentive payments established to drive plans and 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.

Institutions for Mental Disease (IMD) Expenditure Waiver

Currently, federal Medicaid funding cannot be used for institutional services provided to individuals with serious mental illness or severe emotional disturbance (known as the IMD exclusion). However, the federal government has developed an opportunity for states to seek the ability to receive federal funding for institutional services provided to these populations. Through extensive stakeholder engagement, DHCS will assess state and county interest in pursuing the IMD expenditure waiver, as well as readiness of our systems to achieve the required goals and outcomes. Such a proposal must be budget neutral and would allow counties to "opt-in." The main elements of any proposed waiver would include:

- Ensuring 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 waiver 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

Justice involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail, 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 are met like housing, transportation and overall integration back into the community. Studies have shown, such coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. In an effort to ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate the county inmate pre-release Medi-Cal application process by January 2022. Additionally, DHCS is proposing to mandate all counties implement warm-handoffs from county jail release to county behavioral health departments 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 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 eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial

considerations due to realignment and Prop 30 implications. Given the complexity of this proposal, DHCS assumes the selected plans would not go live until 2024, as DHCS and our managed care plans and county partners work together to develop the most appropriate delivery systems for this purpose.

Develop a Long-Term Plan for Foster Care

In 2020, DHCS would like to form a group of 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. Based on the recommendations from such workgroup, DHCS, California Department of Social Services, and other sister departments would work to implement such changes based on timelines developed in the stakeholder process.

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 are different 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 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 accredited
- Implement annual Medi-Cal health plan open enrollment
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
- Administrative behavioral health integration statewide
- Regional contracting
- Substance use disorder managed care program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children
- Pay for Performance for adult and children preventive services 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 contract and demographic information

Managed Care

Managed Care Enrollment

By January 2021, DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries and by January 2023 requiring all dual beneficiaries, statewide to be enrolled mandatorily in a managed care plan, with the exception of those for whom managed care enrollment does not make sense due to limited scope of benefits or limited time enrolled. This will eliminate variation of managed care enrollment practices that currently vary by aid code, population, or geographical location.

Standardize Managed Care Benefit

By January 2021, DHCS proposes to standardize managed care plans benefits, so that all Medi-Cal managed care plans provide the same benefit package. Some of the most significant changes are the carving-in of institutional long-term care and major organ transplants into managed care statewide and, per Executive Order, the carving out of pharmacy.

Transition to Statewide Managed Long-Term Services and Supports

In order 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 to standardized mandatory enrollment of dual eligibles into a Medi-Cal managed care plan for Medi-Cal benefits and integration of long-term care into managed care for all Medi-Cal populations statewide. This will be done in two phases:

January 2021: The Coordinated Care Initiative proceeds as today, however Multipurpose Senior Services Programs will be carved out and all institutional long-term care services will be carved into managed care for all populations enrolled in plans around the state. DHCS will also implement the voluntary in lieu of services benefit at this time.

January 2023: Full transition of the Coordinated Care Initiative to mandatory managed care enrollment of dual eligibles into managed care in all counties/plan models. In addition, require Medi-Cal managed care plans to operate Medicare Dual-Special Needs Plans, in order to offer dual eligible members the ability to have coordinated managed care plans for both their Medi-Cal and Medicare benefits.

The purpose of these transitions and phases is to target a long-term goal of implementing managed long term services and supports (MLTSS) statewide in Medi-Cal managed care beginning in 2026 by providing enough time and incentive to develop the needed infrastructure. This will allow beneficiaries to receive needed MLTSS and home and community based services statewide through their managed care plan, instead of a variety of 1915(c) 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 subcontractors (delegated entities) to be National Committee for Quality Assurance (NCQA) accredited by 2025. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.

Annual Medi-Cal Health Plan Open Enrollment

Effective for plan enrollment as of January 1, 2022, DHCS proposes to implement an Annual Health Plan Open Enrollment process for all managed care plan enrollees. Enrollees would generally only be allowed to change their managed care plan during the Annual Health Plan Open Enrollment period which is consistent with health care industry practice. The Annual Health Plan Open Enrollment period would first begin in November 2021. However in recognition of the concerns previously raised by stakeholders, DHCS has developed this proposal to include a consumer-friendly exemption process that will allow members who have a real need to change plans mid-year to do so in a streamlined way. Enrollment into Medi-Cal coverage would still be allowed throughout the year. This proposal provides the stability required to do effective care and case management of the plan members, while still allowing a simplified process to allow a plan change when it is needed.

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, this also coincides with a shift of the rating period from the state fiscal year to the calendar year beginning in 2020. The proposal to move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with goal of allowing DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates will allow 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 rather than just the experience of plans within the county. This change is fundamental to the ability of DHCS to implement the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps forward to invest in and improve access to mental health and substance use disorder 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, and we recognize that the full needs of the Medi-Cal population are not being met, particularly with respect to improving services and access for children and other vulnerable populations. In order to achieve true reform, DHCS believes that an important first step is undergoing 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. Such a shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation and engage in value-based payment arrangements with their health plan partners in order 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 further build a high quality continuum of care for mental health and substance use disorder 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 modify the medical necessity criteria in order to align with state/federal requirements and more clearly delineate and standardize the benefit statewide.

Administrative Behavioral Health Integration Statewide

Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit from integrated treatment. The State provides Medi-Cal covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, which makes it difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in mental health and substance use disorder managed care 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, counties providing integrated treatment to a Medi-Cal beneficiary must document the substance use disorder service separately from the specialty mental health service. The purpose of this proposal is to make necessary state and county changes that would provide substance use disorder and specialty mental health services through one delivery system.

Behavioral Health Regional Contracting

DHCS recognizes that some counties have resource limitations often due simply to their size and the number of beneficiaries residing in their county. Therefore, 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, 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 is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder fee-for-service might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

DHCS proposes to incorporate the Drug Medi-Cal Organized Delivery System (also known as substance use disorder managed care) into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. DHCS also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewideness. Finally, DHCS is exploring opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

Dental

The Department has set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. In order to progress towards achieving that goal, and based on our lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide:

- Add new Dental Benefits based on the outcomes and successes from the Dental Transformation Initiative that will provide better care and align with national dental care 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 Dental Transformation Initiative 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 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 as identified in a recent audit. This proposal will also ensure that DHCS is compliant with federal and State requirements. These enhancement will be done 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 child beneficiaries. The State delegates certain responsibilities for these high-risk children to California's 58 counties. The State needs to enhance the oversight of counties to ensure they comply with legislation, regulations, and State issued guidance. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the State, 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 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 programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

For more detailed descriptions of the CalAIM proposals please refer to the full CalAIM document located on CalAIM page of the DHCS website.

Advancing Key Priorities

These reforms are interdependent and build off one another; without one, the others are neither possible or powerful.

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other. 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 themselves would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Therefore, carving out prescription drugs from managed care (Medi-Cal Rx) and the other carve-in/carve-outs detailed in the Medi-Cal managed care proposals are necessary and serve as the foundation for DHCS to institute the concepts around not only regional rate setting, but also 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). The Medi-Cal program has evolved over the multiple decades since inception and has relied upon ever-increasing system and fiscal complexity in order to operate and serve the Californians who rely upon it. 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 the most effective with respect to the funding utilized to most efficiently operate the program.

Furthermore, 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 Medicaid can easily integrate, complement and catalyze the Administration's plan to impact 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 advance 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 kids, proliferating the use of value-based payments across our system, including in behavioral health and long-term care. 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, 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 enacted 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, ensuring 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. CalAIM proposes enhanced care management and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries, through 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 Californians (adults and children) will access specialty mental health and substance use disorder services. It aligns the financing structure 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, eligibility for, and access to integrated behavioral health care.

Vulnerable Children: CalAIM would provide access to enhanced care management 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 by, 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 clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/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: The 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. These efforts will support scaling of diversion and reentry 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 felons incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services would allow the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and should be a critical component on the State's Master Plan on Aging.

From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt 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. In addition, given that California has significant learnings from our past 1115 Waivers, 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 new 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 innovation in the Medi-Cal program.

The proposal outlines all elements of the Medi-Cal 2020 waiver and how they will be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or abilities to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes under this federal authority approach. 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 managed care. 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.

CalAIM Stakeholder Engagement

DHCS' intention in the release of these proposals is to garner important input from the many key stakeholders and partners that help us to improve upon these concepts and align them with the expertise and experience of our partners. As previously outlined, DHCS will be undertaking a significant stakeholder engagement effort that begins with the release of this document and continues through the CalAIM workgroups scheduled for November through February, the Stakeholder Advisory Committee (SAC) and Behavioral Health SAC meetings, Medi-Cal Health Advisory Panel (MCHAP) and other convenings. We recognize that CalAIM contains many significant proposals and changes to the Medi-Cal program, aimed at ultimately improving the beneficiary experience and outcomes. However, these represent DHCS' initial proposals and thinking and we look forward to working to refine and modify these proposals relying on the expertise of our stakeholder partners through this engagement process. DHCS plans to finalize all proposals for submission to CMS in the May to July period of 2020 based on the input we will receive from our partners through this process, but also dependent on the funding availability through the state budget process

Conclusion

CalAIM is an ambitious but necessary proposal to positively impact our beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, 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 Californians (adults and children) will access mental health and substance use disorder services including administration of, eligibility for, and access to integrated behavioral health care.

- Provides access to enhanced care management for medically complex children and adults to ensure they get their physical, behavioral, developmental and oral health needs met.

- Builds capacity in clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/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.

- 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 home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and will be a critical component on the State's Master Plan on Aging.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
27. Consider Authorizing a Grant Agreement with the County of Orange for Medical Respite Care

Contact
Tracy Hitzeman, Executive Director, Medical Management, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:
    a. Enter into a Grant Agreement with the County of Orange to fund the County's Post Whole Person Care Medical Respite Program in the amount of $250,000, effective June 1, 2020; and
    b. Amend the Coordination and Provision of Public Health Care Services Contract with the County of Orange to reflect the termination of CalOptima's Medical Respite program effective June 1, 2020.

Background/Discussion
Whole Person Care (WPC) is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home. WPC, including recuperative care, is administer by the Orange County Health Care Agency (OCHCA).

As part of evaluating the progress of the WPC pilot program, it was identified though discussions with OCHCA staff that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy, do not qualify for transition to inpatient stay or nursing facility care, and are believed to benefit from medical respite care beyond the 90 days of available recuperative care. Originally, the County anticipated that approximately two members per month would meet these criteria in order to receive medical respite care.

On April 4, 2019, the CalOptima Board of Directors (Board) established a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the OCHCA WPC pilot. The Board authorized reimbursement of the full medical respite stay at an amount of up to $120 per day for all bed days beyond the days available through the WPC Pilot Recuperative Care Program, not to exceed a cumulative grand total of $250,000, and authorized staff to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services.

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The Medical Respite Program was intended to provide support to CalOptima members experiencing homelessness who (1.) had received WPC recuperative care for the ninety (90) day maximum authorized under the WPC program, (2.) do not meet criteria for inpatient stay or nursing facility placement, (3.) lack a stable living situation, and (4.) whose medical condition(s) necessitate continued services to support the provision of medical treatment and care coordination. CalOptima and County WPC staff collaborated in development of the proposed Medical Respite Program, leveraging the existing WPC infrastructure.

In response to the approval of the Medical Respite Program, CalOptima and County staff amended the Coordination and Provision of Public Health Care Services contract ("County Contract") between the organizations to include Medical Respite services. To date, the Medical Respite Program has not billed for any of the original $250,000 in Board-approved funding. County and CalOptima staff have concluded that it would be more efficient for the County to directly operate the post-WPC Respite Care program, and doing so would allow the County to expand the program and contract with providers as it determines appropriate and consistent with the Grant Agreement. As a result, Staff is recommending that the CalOptima Medical Respite program be terminated and such termination be memorialized by an amendment to the County Contract, effective June 1, 2020. The County's Medi-Cal Respite Program would be funded in the amount of $250,000 through a new Grant Agreement that allows the County to operate and pay for the Medical Respite program directly and without the day-to-day involvement of CalOptima. Grant funds may be applied towards medical respite services already provided to CalOptima Medi-Cal members but not yet billed as such services had been contemplated and were provided under the prior arrangement. The Grant Agreement would include reporting and audit provisions to allow CalOptima to ensure that the funds are used as intended.

Fiscal Impact

The recommended actions to enter into a Grant Agreement with the County of Orange, and to remove the Medical Respite Program from the Coordination and Provision of Public Health Care Services contract has no fiscal impact to CalOptima's operating budget. Pursuant to the Board action taken on April 4, 2019, a reallocation of Intergovernmental Transfer (IGT) 6/7 funds in the amount of $250,000 funded the CalOptima Medical Respite Program. With approval of the recommended actions, CalOptima will allocate these funds to the County Grant Agreement.

Rationale for Recommendation

CalOptima staff recommends the transition of the post-WPC Medical Respite program from CalOptima to the County, which includes approval of a new Grant Agreement with the County for the Medical Respite Program with funding in the amount of $250,000 and an amendment of the County Contract to terminate the existing CalOptima Medical Respite program. Staff believes that this approach is the most effective and efficient way to provide for these Medical Respite services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by the Recommended Action
2. CalOptima Board Action dated April 4, 2019, Consider Authorizing Establishment of a Post Whole Person Care Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

/s/ Richard Sanchez — *05/27/2020*

Authorized Signature — **Date**

Attachment to the June 4, 2020 Board of Directors Meeting– Agenda Item 27

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Orange County Health Care Agency	405 W 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Establishment of a Post Whole Person Care Pilot Medical Respite Care Program and Reallocation of Intergovernmental Transfer (IGT) 6/7 Funds Previously Allocated for Recuperative Care in Conjunction with the Orange County Health Care Agency Whole Person Care Pilot Program

Contacts

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize the establishment of a Medical Respite Program for CalOptima members meeting clinical criteria who have exhausted available recuperative care days under the Orange County Health Care Agency (OCHCA) Whole Person Care Pilot (WPC) program; staff to return to the Board for approval of implementing policies, and obtaining state approval, as appropriate;
2. Authorize reallocation of $250,000 to fund the Medical Respite Program from the $10 million previously allocated IGT 6/7 funds for recuperative care in support of the OCHCA WPC program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's agreement with the County of Orange to allow for reallocation of funds away from the WPC program for medically justified medical respite services for qualifying homeless CalOptima members who have exhausted available recuperative care days under the WPC program.

Background

The WPC is an Orange County-operated pilot program that has and continues to develop infrastructure and integrate systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness. Orange County's WPC application was approved by the Department of Health Care Services (DHCS) in October 2016 which includes provisions for recuperative care services for up to a maximum of 90 days. Recuperative care service is post-acute care for homeless Medi-Cal members who are too ill or frail to recover from a physical illness or injury on the streets, but who do not meet the medical necessity criteria for continued inpatient care and are appropriate for discharge to home.

In May 2017, CalOptima received payment from DHCS for the IGT 6 and 7 transactions and confirmed CalOptima's total share to be approximately $31.1 million. Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. DHCS approved use of IGT 6 and IGT 7 funds to support programs addressing the following areas: Community health investments which may include programs addressing opioid overuse, homeless health care access, children's mental health, adult mental health, childhood obesity, strengthening the safety net, children's health, older adult health and other areas as identified by a member health needs assessment. At the August 2, 2018 Board of Directors meeting, the following four focus areas to support community-based organizations through one-time competitive grants where approved: 1) Opioid and Other Substance Overuse; 2) Children's Mental Health; 3) Homeless Health; and, 4) Community needs identified by the CalOptima Member Health Needs Assessment. A grant allocation of up to $10 million was approved from IGT 6 and 7 Homeless Health priority area to provide recuperative care services for homeless CalOptima members under the WPC

pilot. The funds are currently designated for funding 50 percent of medically justified recuperative care bed days up to a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available. The CalOptima Board of Directors also approved an amendment of the agreement with the County of Orange to include indemnity language and allowing for use of the allocated funds for recuperative care services under the County's WPC Pilot program for qualifying homeless CalOptima members.

Discussion

Since 2016, the OCHCA has collaborated with CalOptima and other community-based organizations, community clinics, hospitals, and county agencies to design and implement the WPC Pilot program. The recuperative care element of the WPC pilot is a critical component of the program. During calendar year 2018, the WPC recuperative care program provided services to 487 unique CalOptima members experiencing homelessness. Between August and December 2018, the average length of stay for these individuals was 34 days, at a cost of $705,250.

As part of evaluating the progress of the WPC pilot program, it has been identified though discussions with OCHCA that some CalOptima members have circumstances that are expected to require a stay beyond the 90 days that are available under the scope of the WPC pilot. These members, such as those who have been certified for hospice care or need intravenous (IV) chemotherapy but do not qualify for transition to skilled nursing care, may benefit from medical respite care beyond the 90 days of recuperative care.

To address this concern, CalOptima staff, with the support of OCHCA WPC staff, and consistent with the approved IGT 6/7 funding categories, is proposing to develop a Medical Respite Program for CalOptima members who need extended medical care beyond the 90 days as provided under the current scope of the WPC Pilot to achieve and maintain medical stability. Staff is in the process of developing policies related to the proposed medical respite program, the purpose of which is to provide short-term residential care to allow individuals with unstable living situations the opportunity to rest in a safe and clean environment while accessing medical care and other supportive services. In addition to providing post-acute care and clinical oversight, medical respite care seeks to improve transitional care for the population and to aid in ending the cycle of homelessness while also gaining stability with case management relationships and programs. As appropriate, staff will seek state approval of this new Medical Respite Program, which is intended to support homeless CalOptima members as they recover and attain medical stability, or in the case of members in hospice, to receive services in a stable environment care. The additional time beyond the days available through the County's WPC program is intended to reduce inappropriate and/or avoidable utilization of hospital Emergency Departments, inpatient admissions and re-admissions.

CalOptima Members nearing the end of their available recuperative days in the WCP program will be evaluated on a case-by-case basis and will need approval by County WPC staff, County Medical Safety Net (MSN) program nurses and CalOptima to be eligible for the Medical Respite Program. Regular reviews and updates will be conducted by the MSN program nurses to ensure that 1) Members do not stay longer than appropriate and 2) Members receive appropriate care to achieve and maintain medical

stability and steps to move to a skilled nursing facility (SNF), if appropriate. It is anticipated that approximately two members per month will meet criteria to receive medical respite care. CalOptima will monitor utilization and member outcomes.

In addition, staff is seeking authority to reallocate $250,000 out of the $10 million the Board allocated to OCHCA WPC program for recuperative care to fund the Medical Respite Program. In other words, no new funding is being proposed. Instead, the recommendation for authority is to redirect dollars previously committed for recuperative care for homeless CalOptima members in coordination with the County's WPC program. Staff is also seeking authority to provide the OCHCA with reimbursement for the full cost of the Medical Respite Program stay at $120 per day, for all bed days beyond the WPC Pilot recuperative care program, not to exceed the requested reallocation amount of $250,000. The OCHCA supports the recommended actions and plans to continue to invoice CalOptima for members in the Medical Respite Program via a similar process such as the already established invoicing process for recuperative care. The funds will be available through the end of the WPC Pilot or until the funds are exhausted, whichever comes first.

Fiscal Impact
The recommended actions to authorize the creation of a Medical Respite Program for CalOptima members and to authorize a reallocation of $250,000 from the $10 million IGT allocation to Orange County Health Care Agency (OCHCA) for recuperative care services, previously approved by the Board on August 2, 2018, has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated September 7, 2017, Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members
2. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

/s/ Michael Schrader — *3/27/2019*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Contact

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

Recommended Actions

1. Approve updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any recuperative care funds paid from this pool to hospitals subsequent to July 31, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority (OCHCA) to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and
3. Authorize expanded use of the above-referenced CalOptima IGT recuperative care funds to include CalOptima Medi-Cal members referred to the County's recuperative care services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings.

Background

Recuperative Care is a program that provides short-term shelter with medical oversight and case management to homeless persons who are recovering from an acute illness or injury and whose conditions would be exacerbated by living on the street.

At its December 4, 2014, and October 1, 2015, meetings, the CalOptima Board of Directors authorized the expenditure of IGT funds for recuperative care services for Medi-Cal members and amendment of hospital contracts to facilitate referrals to and limited reimbursement for recuperative care services. As a result, CalOptima currently provides reimbursement to contracted hospitals for recuperative care services at a rate of up to $150 per day for up to 15 days per member. The total amount of IGT funds that have been allocated for recuperative care is $1,000,000, with $500,000 from IGT 2 and $500,000 from IGT 3. The program launched in May 2015 and as of July 31, 2017, $380,700 has been spent.

The current CalOptima recuperative care program is available for homeless CalOptima members immediately upon discharge from an inpatient hospitalization or emergency room visit and includes: temporary shelter, medical oversight, case management/social services, meals and supplies, referral to safe housing or shelters upon discharge, and communication and follow-up with referring hospitals.

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On December 30, 2015, DHCS received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015, to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

Since the beginning of 2016, OCHCA has collaborated with other county agencies, hospitals, community clinics, community-based organizations, CalOptima and others to design and submit an application to DHCS for WPC in Orange County. The WPC application, approved by DHCS in October 2016, includes provisions for recuperative care. The WPC recuperative care program serves CalOptima members discharged from hospitals (inpatient stays and emergency room visits) and skilled nursing facilities, as well as those directly referred from clinics and OCHCA public health nurses. The DHCS/County Contract, executed in June 2017, states that "if the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay [assuming available funds] for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC pilot will be responsible for reimbursement for the entire 90-day stay."

Discussion

WPC Pilots must include strategies to increase integration among county agencies, health plans, providers, and other entities within each participating county. Orange County's WPC Pilot is intended to focus on improving outcomes for participants who are homeless and frequently visit local hospital emergency departments. By leveraging existing programs and offering new and enhanced services, the intent of the WPC pilot is to improve access to medical care, social services and housing for participants. Over the course of the program, the WPC Pilot is expected to reduce emergency department and hospital visits, increase visits to primary care/other providers and help participants find permanent housing.

Recuperative care is a critical component of Orange County's WPC Pilot. Depending on member need, as determined on a case-by-case basis, the County's recuperative care program will be responsible for paying for recuperative care services for up to 90 days and is available for homeless Medi-Cal members being discharged from hospitals and skilled nursing facilities. Further, it is available to homeless Medi-Cal members referred by a clinic or public health nurses who might otherwise go to the hospital for care that could be provided in a residential or clinic setting. As indicated above, pursuant to the terms of the DHCS/County Contract, funds provided by CalOptima are only being used for up to the first 15 days of WPC services to Medi-Cal beneficiaries who are being admitted into recuperative care directly from a hospital contracted with CalOptima.

Hospitals currently participating in CalOptima's recuperative care IGT initiative have entered into a Recuperative Care addenda to their existing CalOptima contracts. This allows hospitals to receive reimbursement from CalOptima for up to 15 days of recuperative care at up to $150 per day. As proposed, staff is seeking authority to redirect remaining CalOptima IGT 2 and 3 recuperative care

funding from CalOptima's existing hospital-based program to the County's WPC program. While the WPC permits stays of up to 90 days, the County must "pick up payment for recuperative/respite care after CalOptima stops payment." Consistent with the WPC Pilot, CalOptima would continue to make the IGT funds allocated for recuperative care available up to a maximum of $150/day for up to 15 days per member for qualifying members transitioning to recuperative care from a hospital setting, contingent upon member need and availability of funds, pursuant to the program approved by DHCS. Qualifying recuperative care services resulting from referrals from skilled nursing facilities, clinics, and public health nurses are currently the financial responsibility of the County, and the current DHCS/County Contract indicates that CalOptima is not involved in funding recuperative care services for Members entering recuperative care from these settings.

Staff seeks authority to enter into a grant agreement with the County to redirect the remaining available IGT 2 and 3 recuperative care funds to the County's recuperative care program as discussed above. As a part of the grant agreement, the reimbursement process for recuperative care will be changed. Hospitals will no longer be expected to directly pay for and then seek reimbursement from CalOptima for referrals of homeless CalOptima members to recuperative care. As proposed, OCHCA will invoice CalOptima for up to the first 15 days of recuperative care services referred from a hospital or emergency room (at a rate of up to $150/day).

Once the grant agreement with the County is in place, CalOptima contracted hospitals will no longer be eligible to obtain reimbursement for recuperative care services from CalOptima for the duration of the WPC Pilot. However, until such time, to the extent that funds remain available, CalOptima will continue to reimburse hospitals that bill CalOptima directly for reimbursement for qualifying members. CalOptima and OCHCA staff will coordinate and maintain processes to ensure no duplication of payments.

As indicated, CalOptima funding for the program is limited to those funds remaining from those allocated to the existing CalOptima recuperative care program operated through its contracted hospitals, and invoice payments will be made only until those funds are exhausted.

Potential Broadening of Eligibility Categories. While the current DHCS/County Contract specifies that CalOptima funds are to be used exclusively for homeless members discharged from CalOptima-contracted hospitals to a recuperative care setting, the County is proposing to allow for the use of CalOptima funds for services to members admitted to recuperative care from other settings including skilled nursing facilities and clinics and by public health nurses, in addition to members referred from contracted hospitals. This proposed approach could increase the flexibility in administration of the program, and broaden the range of members covered by the allocated funding. Staff is requesting, subject to amendment of the DHCS/County Contract, that the Board authorize broader use of the remaining IGT 2 and 3 funds allocated for recuperative care, consistent with an amendment of the DHCS/County Contract, or other written approval from DHCS, allowing such use of CalOptima funds. As proposed, the maximum $150 daily payment rate and 15 day maximum stay currently applicable to referrals from contracted hospitals would also apply to referrals from such additional sources.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Of the $1.0 million in IGT funds approved by the Board for recuperative care, remains available as of July 31, 2017. Payments for recuperative care services provided under this staff recommendation are contingent upon availability of existing IGT funds. Any additional funding for recuperative care would require future Board consideration and approval. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working "Better. Together." CalOptima, as the community health plan for Orange County, is committed to working with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services for Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 4, 2014, Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
2. Board Action dated October 1, 2015, Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose, and authorize hospital contract amendments as necessary to implement the proposed modifications to the recuperative care program.

Rev. 10/1/15

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader *9/25/2015*
Authorized Signature **Date**

CalOptima
A Public Agency
Better. Together.

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

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IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements



- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents ~~23%~~ between 2-3% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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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
17. Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Funds

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

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

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Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Finance and Audit Committee

Report Item

9. Consider Recommending Board of Directors' Authorization of Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2020–2021 Capital Budget

Contacts

Ladan Khamseh, Chief Operating Officer, 714-246-8866
David O'Brien, Director Information Services, 714-246-1269

Recommended Action

Recommend that the Board of Directors authorize reallocation of budgeted but unused funds in the amount of up to $430,000 from the Network – Wireless System Upgrade project to fund the Telephony – Upgrade Contact Center project through June 30, 2021

Background/Discussion

CalOptima's telephony infrastructure utilizes a mixed environment of Avaya and Nortel systems for the Private Branch Exchange (PBX) and Call Center services. As of August 2020, much of CalOptima's telephony hardware and software will be at the end of manufacturer support. Manufacturers' end-of-support designation greatly reduces the level of support we receive in the event of an issue. Additionally, with many of the hardware components more than 10 years old, the age of the equipment has passed its useful and expected life, increasing the likelihood of failure.

The telephony and Call Center infrastructure systems are critical to CalOptima's ability to communicate internally and, most importantly, communicate externally with our members and provider partners. A service disruption or extended outage of these systems would greatly impact our ability to communicate with members and providers. This necessary upgrade was slated in two stages due to current fiscal year (FY) budget constraints, with the first portion budgeted and approved in FY 2020, for $50,000 to improve the "call flow" configurations within our Avaya call center software. The remainder of the project was slated for FY2021.

Additionally, in FY 2020, CalOptima's IS Department budgeted $430,000 as part of an approved project to upgrade the wireless network infrastructure within the 505 building. The existing infrastructure is old, having been implemented during the move to the 505 building nearly 10 years earlier. An upgrade of these systems would provide faster and more stable wireless services throughout the facility. However, due to COVID-19 precautions, only approximately 10% of the CalOptima workforce is presently working at the 505 building. This upgrade, while needed, is not as critical to our ability to support our members and providers.

To ensure that CalOptima can provide a stable and secure telephony services for our personnel, members and provider partners, management recommends reprioritizing these two initiatives to address the completion of the telephony upgrade earlier, and defer the upgrade of the wireless infrastructure to FY 2021-22. The Telephony - Upgrade Contact Center project is included in the FY 2020-21 Capital Budget that was approved by the Board on June 4, 2020, in the amount of $50,000 (i.e., $25,000 in Hardware and

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$25,000 in Software). Management proposes to reallocate $430,000 from the Network – Wireless System Upgrade project to fund the Telephony – Upgrade Contact Center project. Specifically, the following amounts would be reallocated from Network – Wireless System Upgrade – Hardware:

- Up to $15,000 to Telephony --Upgrade Contact Center – Hardware;
- Up to $300,000 to Telephony –Upgrade Contact Center – Software; and
- Up to $115,000 to Telephony – Upgrade Contact Center – Professional Fees**.**

This will ensure adequate support and response times from our vendors as necessary. Assuming the Board approves the recommended reallocation, Staff plans to include the network wireless upgrade in the FY 2021-22 Capital Budget.

CalOptima will also be able to take advantage of the 2020 discounted pricing from Avaya and our systems integrator. Additionally, with a supported infrastructure, our annual operational maintenance cost, starting in FY 2022, is expected to be reduced by 31%.

Fiscal Impact
The fiscal impact for the recommended action is budget neutral. Unspent budgeted funds from the Network – Wireless System Upgrade project included in the Board-approved FY 2020-21 Capital Budget will fund the total cost of up to $430,000 for this action.

Rationale for Recommendation
To ensure that CalOptima's Telephony infrastructure, including the call centers, continues to function properly and reliably to support the organization, members and providers.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *11/10/2020*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Avaya Inc.	2605 Meridian Parkway, STE 200	Durham	NC	27713
Dell	One Dell Way	Round Rock	TX	78682
Intelli-Flex/Telanet	17315 Studebaker Rd. Ste 332	Cerritos	CA	90703
Microsoft	One Microsoft Way	Redmond	WA	98052
Nth Generation	17055 Camino San Bernardo	San Diego	CA	92127
CenturyLink / Lumen	19000 MacArthur Bl, Ste. 400	Irvine	CA	92612

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CalOptima

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Introduction to the Investment Advisory Committee (IAC)

Board of Directors' Finance and Audit Committee Meeting

November 19, 2020

Patrick K. Moore, IAC Chair

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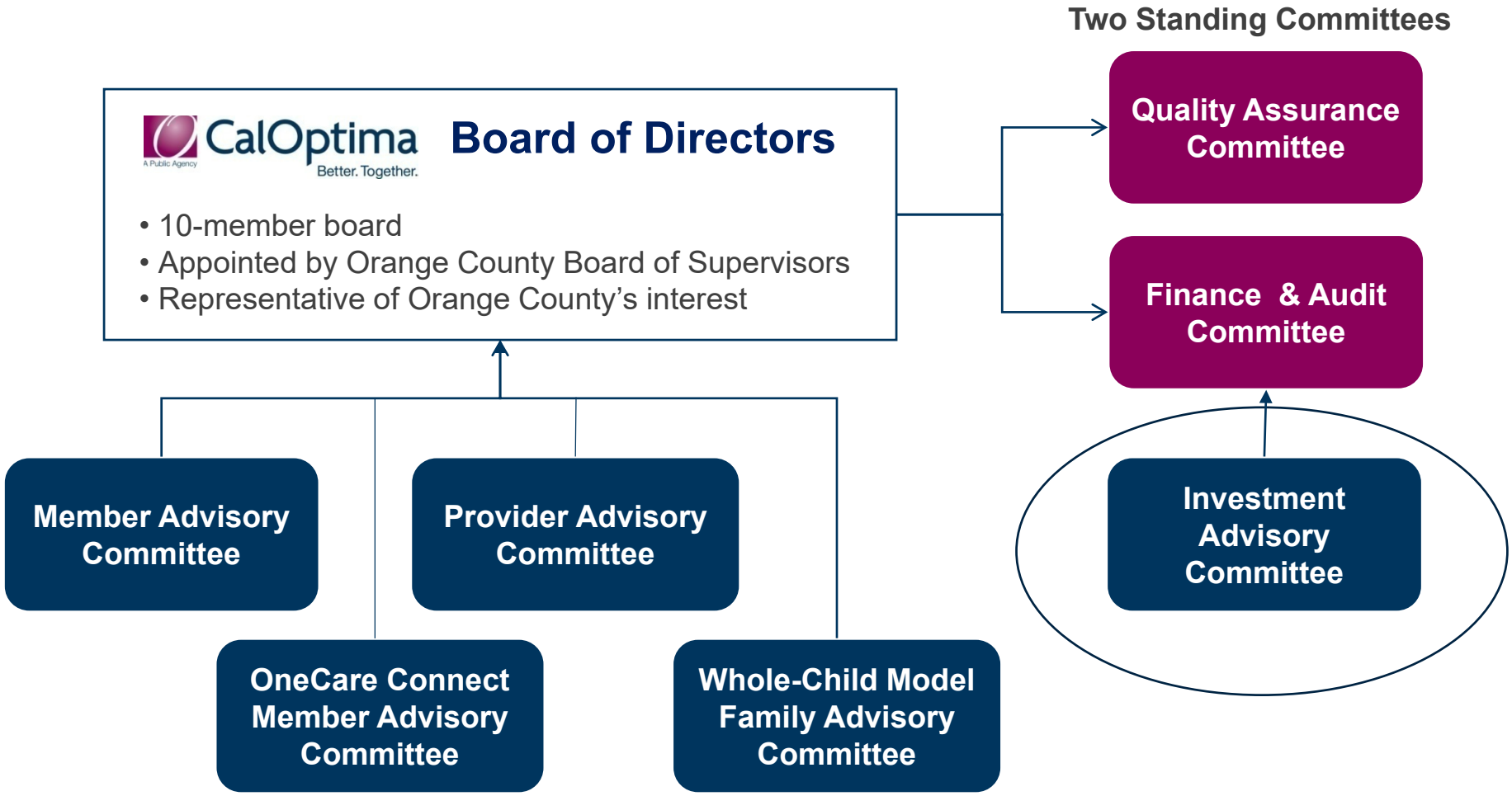
Governance



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CalOptima A Public Agency

Committee Overview

- Authority: Article VII of the Bylaws (9/10/96)
- Purposes:
  - To advise and make recommendations on CalOptima's investment program to FAC
  - To provide governance-level oversight of investment program
- Frequency of regular meetings: Quarterly
- Compensation: None
- Appointment
  - IAC recommends appointment to FAC
  - FAC recommends appointment to the Board of Directors

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Committee Composition

- Number of members: 7
- Term: 2-year terms with no term limits
- Residency: Legal residents or employed in Orange County
- Qualifications: Experience in one or more of the following:

• Commercial banking	• Financial accounting
• Investment banking	• Financial management and planning
• Investment brokerage and sales	• Investment management
• Investment management	• Other relevant experience

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2020 IAC Members

Name	Occupation	Company
Patrick Moore (Chair)	Attorney at Law	Patrick K. Moore Law Corporation
Colleen Clark	Former Director of Public Finance	County of Orange
Caroline Harkins	Former Regional President	Bridge Bank
Nancy Huang	Chief Financial Officer and Treasurer	CalOptima
David Hutchison	Partner, Portfolio Manager	Triad Investment Management, LLC
Rodney Johnson	Senior Director, Finance	Los Angeles County Transportation Authority
David Young	Founder & Chief Executive Officer	Anfield Capital Management, LLC

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CalOptima
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Committee Responsibilities

- Consultation:
  - Advise on investment procedures
  - Recommend investment program strategies to staff
  - Recommend selection of investment advisor and managers to FAC
- Oversight:
  - Annual review of the Investment Policy and recommend revisions to FAC
  - Quarterly portfolio/compliance/economic review to ensure compliance with the Investment Policy and the California Government Code and evaluate total return
  - Prohibited from directing staff or managers to make an investment or to do business with any particular investment company or broker

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CalOptima
A Public Agency

CalOptima Investment Goals

- Safety of Principal
  - Minimize capital losses
  - Mitigate credit and market risks
  - Comply with “prudent investor” standard
- Total return
  - Attain at least a market-average rate of return within scope of Investment Policy
- Liquidity
  - Satisfy cash flow requirements of CalOptima while preserving safety of principal and total return

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CalOptima
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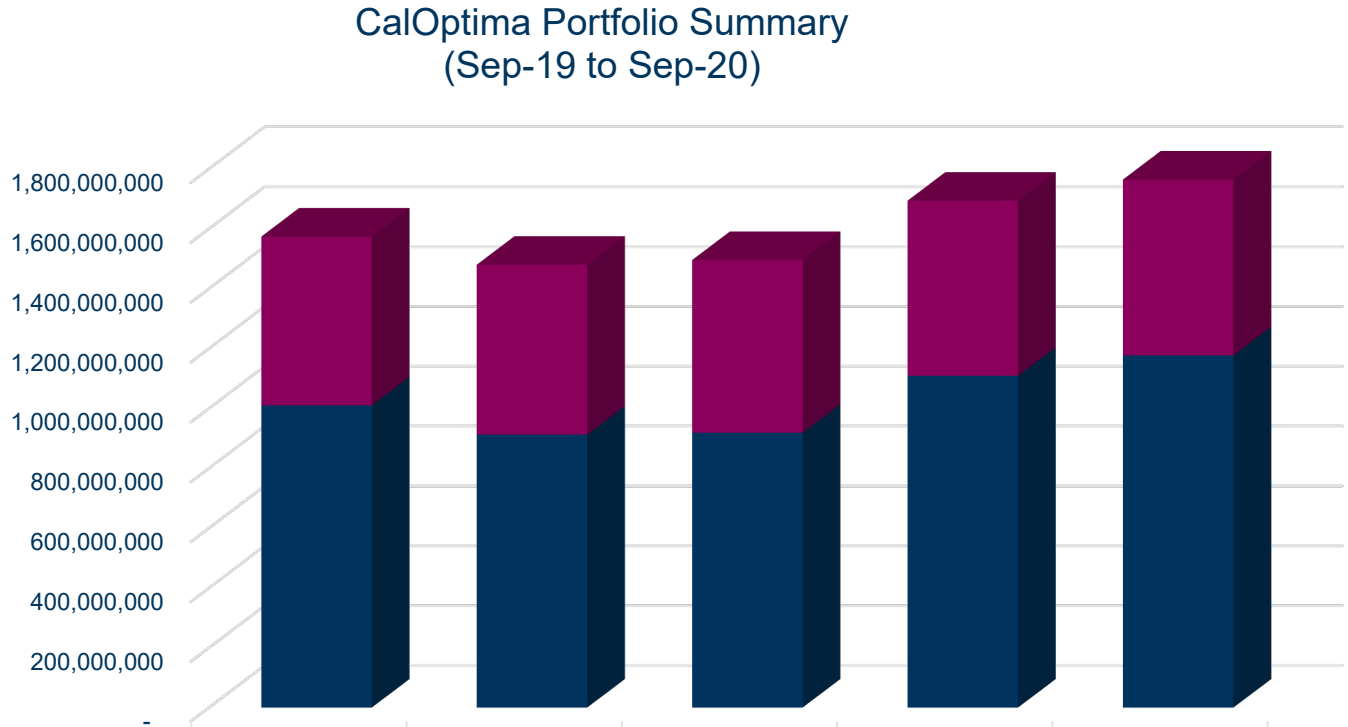
Portfolio Summary by Investment Types



	Sep-2019	Dec-2019	Mar-2020	Jun-2020	Sep-2020
Investment	563,881,942	567,080,832	576,822,608	584,883,893	587,226,318
Cash and Cash Equivalent	1,010,238,480	912,872,228	918,883,674	1,108,981,517	1,177,316,536

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CalOptima
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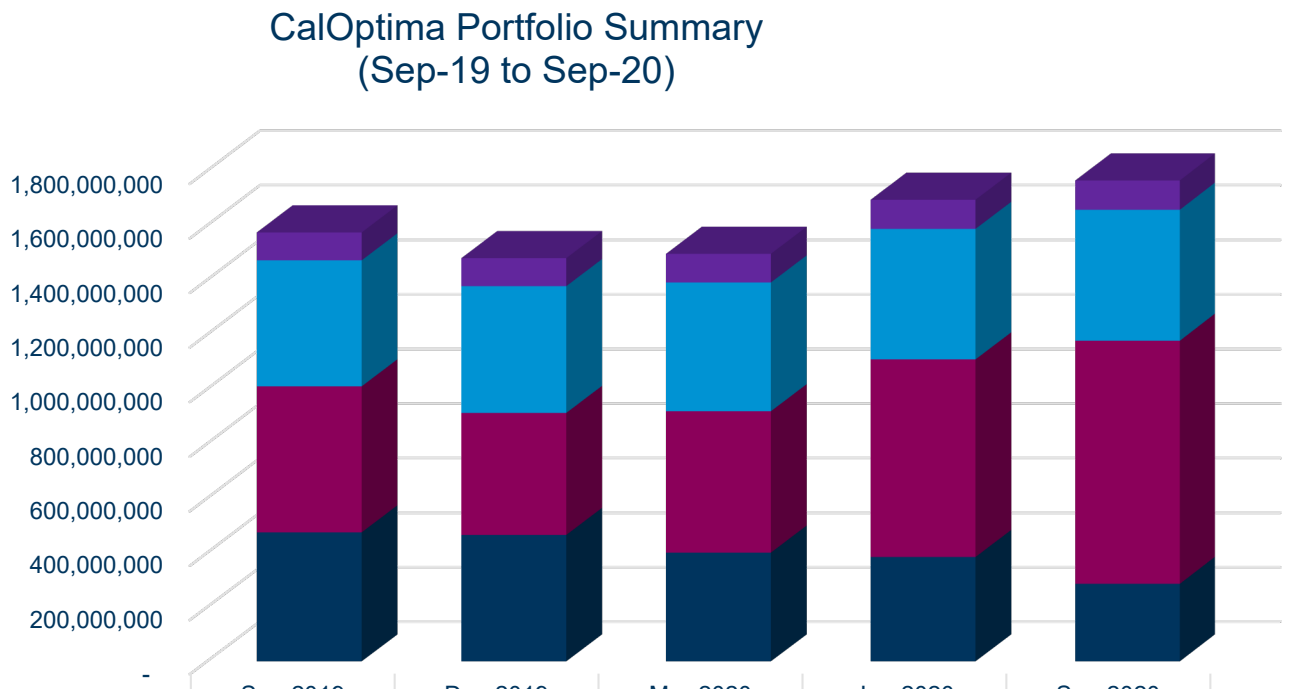
Portfolio Summary by Tier Types



	Sep-2019	Dec-2019	Mar-2020	Jun-2020	Sep-2020
Tier 2	102,111,708	102,643,334	104,914,407	106,678,675	107,303,662
Tier 1	461,770,234	464,437,498	471,908,201	478,205,218	479,922,656
Custody - Short Term Investment	535,122,042	447,167,503	517,992,081	724,076,886	891,065,210
Custody - Cash and Cash Equivalent	475,116,439	465,704,724	400,891,593	384,904,631	286,251,326

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Portfolio Composition

- Asset allocation:
  - Fixed income and other investments permitted by Investment Policy
  - Diversification restrictions per the Investment Policy and the California Government Code

- "Funds" – Performance Benchmarks:
  - Operating Fund – FTSE T-Bill Months TR
  - Tier 1 - BofA Merrill Lynch 1-3 Years Treasury/US Corp & Govt AAA-A
  - Tier 2 - BofA Merrill Lynch 1-5 Years Treasury/US Corp & Govt AAA-A

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Oversight of Investment Consultants

- Investment Advisor – Meketa Investment Group
  - Performance review (gross/net returns, risk evaluation, industry benchmark comparison, attribution, “custom peer group” ranking)
  - Compliance review
  - Economic forecast

- Investment Managers:
  - Payden & Rygel (Operating Fund/Tier 1)
  - Wells Fargo Asset Management (Operating Fund/Tier 1)
  - MetLife Investment Management (Operating Fund/Tiers 1 & 2)

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Oversight of Investment Consultants (cont.)

- Information sources:
  - Management:
    - Organizational updates
    - Operational updates relevant to investment program
    - Financial statements
  - Investment Advisor
    - Performance review (total return, attribution, benchmark comparison, “custom peer group” benchmarking)
    - Compliance review
    - General economic forecast

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Oversight of Investment Consultants (cont.)

- Investment Managers:
  - Allocation and investment review
  - Performance review (asset class allocation, particular investments, return, attribution, industry benchmark comparison)
  - Compliance review
  - General and investment specific economic forecasts

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CalOptima
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Interface with FAC

- Provide information to assist FAC in fulfilling its responsibilities:
  - Quarterly Investment Advisor “roll-up” performance and compliance reports
  - Quarterly Investment Manager individual performance and compliance reports
  - Quarterly meeting minutes
- Discuss recommendations at request of FAC:
  - FAC may send IAC’s recommendation back for further information or consideration

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CalOptima
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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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CalOptima

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Overview of Office of Compliance

Board of Directors' Finance and Audit Committee Meeting

November 19, 2020

Silver Ho

Executive Director, Compliance

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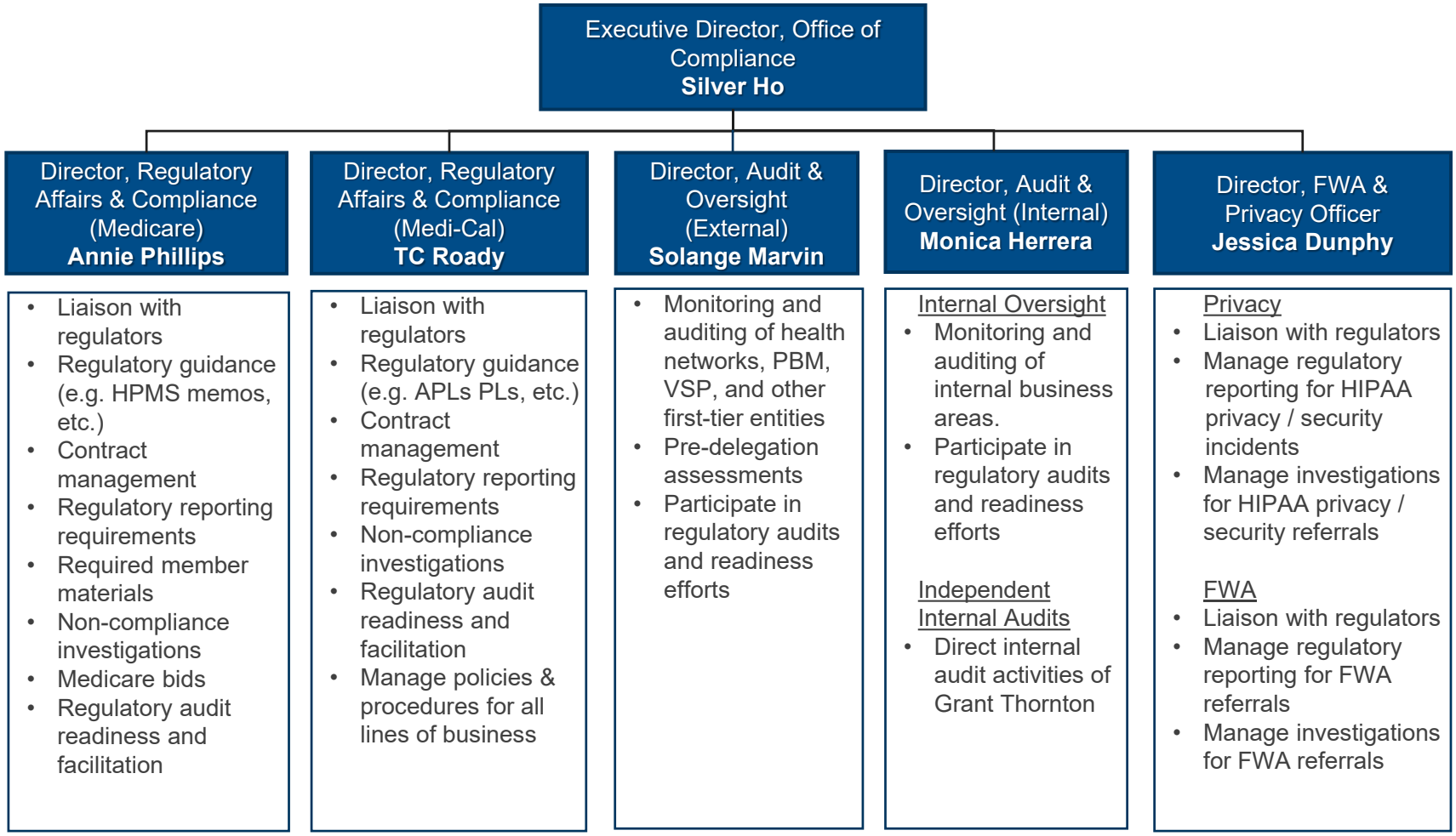
Office of Compliance



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CalOptima
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Oversight Activities

I. CalOptima's Audit & Oversight Activities
   - External
   - Internal

II. Grant Thornton
   - Independent Internal Audits

III. Regulatory Audits
   - Centers for Medicare & Medicaid Services (CMS)
   - Department of Health Care Services (DHCS)

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CalOptima
A Public Agency

I. Audit & Oversight

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CalOptima
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Auditing Activity

- CalOptima's Audit & Oversight (A&O) department is responsible for the oversight of both internal operations and functions performed by delegates on behalf of CalOptima.
- The A&O (external) department conducts annual audits of CalOptima's health works, Pharmacy Benefit Manager (PBM), and vision service provider (VSP).

Audit Areas	
Access & Availability	Medi-Cal Addendum
Care Delivery Model	Member Grievances & Appeals
Claims	Network Management
Compliance	Provider Network Contracting
Credentialing	Provider Relations
Cultural Linguistics	Quality Improvement
Customer Service	Sub-Contractual
Encounters	Translation Services
Information Systems	Whole Child Model
Mailroom Process	Utilization Management
Marketing	

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CalOptima
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Auditing Activity (cont.)

- CalOptima's A&O (External) department also performs annual onsite audits for its first-tier entities (FTEs) to assess the following areas:

Audit Areas	
Program Management	Insurance
Paper Document Control and Record Retention	Sub-contractual
Data and System Security	Fraud Waste & Abuse (FWA)
Business Continuity and Disaster Recovery	Physical Compliance
HIPAA Privacy and Security	

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CalOptima
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Auditing Activity (cont.)

- CalOptima's A&O (Internal) department conducts annual audits of CalOptima's departments for the following areas.

Audit Area	
Access and Availability	Provider Directory and Training
Behavioral Health Authorizations & Treatment Plan's Adherence to APL 19-010 and APL 19-014	Pharmacy Appeals and Prior Authorization Process
Case Management and Coordination of Care	Formulary and Benefit Administration
Medicare-Medicaid Plan (MMP) Care Coordination and Quality Improvement Program Effectiveness (CCQIPE)	Medication Therapy Management (MTM)
SNP Model of Care (MOC)	Part D Coverage Determinations, Appeals and Grievances (CDAG)
Claims Processing	Potential Quality of Care
Credentialing Process	MMP Service Authorization Requests, Appeals and Grievances (SARAG)
Call Inquiries/ Exempt Grievances	Part C Organization Determinations, Appeals and Grievances (ODAG) Program
Call Logs	Grievances and Appeals

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CalOptima
A Public Agency

Monitoring Activity

- CalOptima's A&O department also performs ongoing monitoring to ensure adherence to regulatory and contractual standards as well as CalOptima policies and procedures.

- For health networks, the A&O (external) department monitors the following areas by line of business:
  - Claims – Monthly
  - Credentialing – Monthly
  - Provider Directory – Quarterly
  - Utilization Management – Monthly

- For internal business areas, the A&O (internal) department monitors the following areas by line of business:
  - Utilization Management – Monthly
  - Appeals and Grievances – Monthly
  - Exclusion Monitoring – Monthly

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CalOptima
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Monitoring Activity (cont.)

- As part of the monitoring process, CalOptima's Audit & Oversight (A&O) department, in collaboration with internal business areas, has created a dashboard to track key metrics, including, but not limited to, utilization management, coverage determinations, complaints, appeals, grievances, credentialing, customer service, and claims.
  - On a monthly basis, data are submitted by the health networks and internal business areas and incorporated into a dashboard to monitor key performance indicators such as, timeliness and accuracy.
  - Dashboards are presented to CalOptima's Audit & Oversight Committee (AOC) and Compliance Committee for oversight and for any recommendations for corrective action(s) should metrics fall below the threshold.
  - If there is a consistent pattern of non-compliance by the internal business area and/or health network, the A&O department may conduct a focused review and/or issue a request for a corrective action plan (CAP).

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CalOptima
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Health Network Monitoring Dashboard: Medi-Cal (EXAMPLE)

Area	Measure	Goal
Utilization Management (UM)	Percentage of routine authorization requests processed within required timeframe	>= 98%
	Percentage of expedited authorization requests processed within required timeframe	>= 98%
	Denial rate	<= 5%
	Denial rate for lack of medical necessity	<= 2.5%
	UM universe submission timeliness	100%
	Outstanding number of errors on UM XML universe	0
	Expedited - File Review	
	Letter review	>= 98%
	Timeliness	>= 98%
	Clinical decision making review	>= 98%
	Routine - File Review	
	Letter review	>= 98%
	Timeliness	>= 98%
	Denials - File Review	
	Letter review	>= 98%
	Timeliness	>= 98%
	Clinical decision making review	>= 98%
	Modifications - File Review	
	Letter review	>= 98%
	Timeliness	>= 98%
	Clinical decision making review	>= 98%
	Extended - File Review	
	Letter review	>= 98%
	Timeliness	>= 98%
	Clinical decision making review	>= 98%

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CalOptima
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Internal Monitoring Dashboard: Medi-Cal (EXAMPLE)

Department	Measure	Goal
Claims	Total Claims Received	N/A
	Total Claims Denied	N/A
	Total Claims Paid	N/A
	Dollar Amount of Interest Paid	N/A
	Electronic Claim Acknowledgement ≤ 2 Business Days	95%
	Paper Claim Acknowledgement ≤ 15 Business Days	95%
	Timely Forwarding of Misdirected Claims ≤ 10 Business Days	95%
	Clean Claims Paid or Denied ≤ 30 Calendar Days	95%
	Unclean Claims Paid or Denied ≤ 45 Business Days	95%
	Emergency Claims Denied Due to Prior Authorization	0%
	Family Planning Claims Denied Due to Prior Authorization	0%
	Acknowledgement Timeliness	95%
	Processing Accuracy	95%
	Resolution Timeliness	95%
	Interest Accuracy and Timeliness ≤ 5 Working Days	95%
	Check Clearing Timeliness	70%
Customer Service - Call Inquiries	Calls Answered ≤ 30 Seconds or Less (Service Level)	80.0%
	Abandonment Rate of Incoming Customer Calls	≤5%
	Average Speed of Answer (ASA) ≤ 30 Seconds	≤30 seconds

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II. Independent Internal Audits: Grant Thornton

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Independent Internal Audits

- Grant Thornton has been selected to perform internal audits of CalOptima's business areas based on its risk assessment and audit workplan.
- Risk assessment is currently in progress, and was temporarily paused to ensure new Board members are captured in interview process.
- Audit workplan will be developed based on the risk assessment, and presented to the Finance & Audit Committee in February 2021.
- In the interim, based on the preliminary risk assessment, two (2) audits will be performed in the areas of Vendor Management and CalOptima's process for implementing regulatory requirements.

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III. Regulatory Audits

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Regulatory Audits

Medicare	Medi-Cal
OneCare/OneCare Connect Program Audit	DHCS Medical Audit
PACE Program Audit	DHCS Medical Audit for Medi-Cal and OneCare Connect Medicaid-based Services
Financial Audit (1/3 Financial Audit)	DHCS Rate Development Template (RDT) Audit
Part C National Risk Adjustment Data Validation (RADV) Audit	DHCS Medical Loss Ratio (MLR) Audit
Part C Contract Level (RADV) Audit	DMHC Routine Financial Audit
Medical Loss Ratio (MLR) CMS Desk Review	Annual Network Certifications
Compliance Program Effectiveness (CPE) Audit	Readiness Checklists
Parts C and D Data Validation Audit (DVA)	
Part D Prescription Drug Event Validation (PEPV)	
Performance Measure Validation (PMV)	
Audit of Part D Payments for Drugs Included in End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)	
Timeliness Monitoring of Organization Determinations, Appeals & Grievances (ODAG)	
Monitoring of Posted Comprehensive Formularies	
Three-Year Provider Network Adequacy Review	
CMS Readiness Checklist	

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Governance Structure

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Governance Structure

- Board of Directors
  - CalOptima's Office of Compliance reports general compliance activities, including monitoring and audit activities to CalOptima's Board of Directors monthly.
  - Significant updates on compliance activities may also be provided in weekly Board communications.
- Finance & Audit Committee (FAC)
  - Financial audits (e.g., Moss Adams, etc.)
  - Other audits conducted by independent auditors (Grant Thornton)
- Compliance Committee
  - CalOptima's Office of Compliance reports general compliance activities, including significant issues of non-compliance, internal/external monitoring and audit activities, regulatory audits, HIPAA privacy, and FWA updates on at least a quarterly basis.
- Audit & Oversight Committee (AOC)
  - CalOptima's Office of Compliance reports internal/external monitoring and audit activities, including performance dashboards on at least a monthly basis.

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Update: 2020 DHCS Medical Audit Corrective Action Plan (CAP)

Board of Directors' Finance & Audit Committee Meeting
November 19, 2020

TC Roady, Director,
Regulatory Affairs & Compliance (Medi-Cal)

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Background

- Three Scopes
  - Non-seniors and persons with disabilities (Non-SPD) Medi-Cal members (*annual*)
  - SPD Medi-Cal members (*tri-annual*)
  - Medicaid-based services in Cal MediConnect (*tri-annual*)
- Delegate Involvement (Monarch)
- Review Areas
  - Utilization Management
  - Case Management & Coordination of Care
  - Availability and Accessibility
  - Member's Rights
  - Quality Management
  - Administrative and Organizational Capacity



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Findings

- Access and Availability of Care (3 findings)
  - The Plan did not communicate and enforce providers' compliance with the timeliness standards because the survey report outcome did not identify and analyze the performance of non-compliant individual providers.
  - The Plan did not effectively monitor wait times for member calls to providers' offices (speed to answer and return calls).
  - The Plan did not communicate, enforce, and effectively monitor providers' compliance with in-office wait times. The Plan was not able to identify individual non-compliant providers.
- Grievance System (4 findings)
  - The Plan does not have a policy and procedure (P&P) to distinguish a grievance from an inquiry.
  - The Plan did not correctly identify and process quality of care (QOC) grievances.
  - The Plan did not immediately submit all the QOC grievances to its medical director for action.
  - The Plan sent resolution letters to members without completing the investigation process to resolve both quality of service and quality of care grievances.

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CAP Update

- September 11: CAP was formally submitted to DHCS
- September – October: CalOptima responded to various inquiries from DHCS as it reviewed the CAP, as is customary
- October 27: CalOptima requested two revisions to the CAP:
  - Revise a provider-facing letter to improve tone and reflect educational intent; and
  - Revise in-office wait time monitoring methodology to leverage outbound calls from CalOptima to members as opposed to inbound calls from members to CalOptima.

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Ongoing Efforts and Next Steps

- DHCS continues to review the CAP and engage CalOptima in ongoing dialogue, offering feedback and support.
- CalOptima will continue to implement the various provisions of the CAP, many of which are in progress or slated to occur during Q4.
- CalOptima will continue to provide monthly status updates to DHCS on its progress implementing the CAP.
- Staff anticipates that DHCS will likely accept and close the CAP in Q1 2021.

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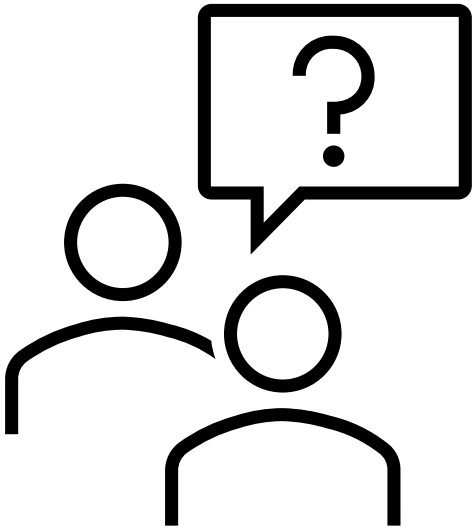
Questions



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Financial Summary

September 30, 2020

Board of Directors' Finance and Audit Committee Meeting
November 19, 2020

Nancy Huang, Chief Financial Officer

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FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $6.5 million, favorable to budget $3.7 million or 132.8%
  - YTD: $1.4 million, favorable to budget $4.3 million or 148.1%
- Enrollment
  - MTD: 787,920 members, favorable to budget 527 or 0.1%
  - YTD: 2,340,406 member months, favorable to budget 3,565 or 0.2%
- Revenue
  - MTD: $423.7 million, favorable to budget $102.1 million or 31.8%
    - Driven by Medi-Cal line of business (LOB) $103.2 million of fiscal year (FY) 2019 hospital Directed Payments (DP) and $4.9 million of Whole Child Model (WCM) prior year revenue due to restated enrollment, offset by Proposition 56 risk corridor estimate
  - YTD: $1.0 billion, favorable to budget $72.1 million or 7.5% driven by Medi-Cal line of business:
    - Primarily driven by Medi-Cal LOB FY 2019 hospital DP, offset by bridge period Gross Medical Expense (GME) and Proposition 56 risk corridor estimates

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FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $405.6 million, unfavorable to budget $98.3 million or 32.0%
    - Driven by Medi-Cal LOB $103.2 million unfavorable variance due to hospital DP, offset by decrease in utilization due to COVID-19 pandemic
  - YTD: $996.6 million, unfavorable to budget $70.8 million or 7.6%
    - Primarily driven by Medi-Cal LOB FY 2019 hospital DP, offset by decrease in utilization due to COVID-19 pandemic
- Administrative Expenses
  - MTD: $11.4 million, favorable to budget $1.3 million or 10.0%
  - YTD: $33.4 million, favorable to budget $5.0 million or 13.1%
- Net Investment & Other Income
  - MTD: ($0.1) million, unfavorable to budget $1.4 million or 110.2%
  - YTD: $1.6 million, unfavorable to budget $2.1 million or 56.8%

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FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 95.7% (94.4% excluding DP), Budget 95.6%
  - YTD: Actual 96.8% (96.4% excluding DP), Budget 96.7%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 2.7% (3.6% excluding DP), Budget 3.9%
  - YTD: Actual 3.2% (3.6% excluding DP), Budget 4.0%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.95
  - Net position: $1.0 billion, including required Tangible Net Equity (TNE) of $102.4 million

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Enrollment Summary: September 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
113,044	110,857	2,187	2.0%	SPD	338,554	332,449	6,105	1.8%
518	485	33	6.8%	BCCTP	1,538	1,467	71	4.8%
289,351	306,002	(16,651)	(5.4%)	TANF Child	869,380	905,027	(35,647)	(3.9%)
97,148	92,042	5,106	5.5%	TANF Adult	287,432	272,323	15,109	5.5%
4,891	3,509	1,382	39.4%	LTC	14,495	10,521	3,974	37.8%
253,445	246,699	6,746	2.7%	MCE	748,328	731,588	16,740	2.3%
13,020	11,932	1,088	9.1%	WCM	31,359	35,796	(4,437)	(12.4%)
771,417	**771,526**	**(109)**	**(0.0%)**	**Medi-Cal Total**	**2,291,086**	**2,289,171**	**1,915**	**0.1%**
14,529	**14,080**	**449**	**3.2%**	**OneCare Connect**	**43,535**	**42,321**	**1,214**	**2.9%**
1,594	**1,378**	**216**	**15.7%**	**OneCare**	**4,642**	**4,134**	**508**	**12.3%**
380	**409**	**(29)**	**(7.1%)**	**PACE**	**1,143**	**1,215**	**(72)**	**(5.9%)**
787,920	**787,393**	**527**	**0.1%**	**CalOptima Total**	**2,340,406**	**2,336,841**	**3,565**	**0.2%**

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Financial Highlights: September 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
787,920	787,393	527	0.1%	Member Months	2,340,406	2,336,841	3,565	0.2%
423,665,786	321,534,801	102,130,985	31.8%	Revenues	1,029,727,484	957,580,299	72,147,185	7.5%
405,600,875	307,305,145	(98,295,730)	(32.0%)	Medical Expenses	996,560,330	925,748,842	(70,811,488)	(7.6%)
11,398,770	12,670,898	1,272,128	10.0%	Administrative Expenses	33,405,555	38,453,777	5,048,222	13.1%
6,666,141	**1,558,758**	**5,107,383**	**327.7%**	**Operating Margin**	**(238,402)**	**(6,622,320)**	**6,383,918**	**96.4%**
(127,077)	1,250,000	(1,377,077)	(110.2%)	Non Operating Income (Loss)	1,621,158	3,750,000	(2,128,842)	(56.8%)
6,539,064	**2,808,758**	**3,730,306**	**132.8%**	**Change in Net Assets**	**1,382,757**	**(2,872,320)**	**4,255,077**	**148.1%**
95.7%	95.6%	(0.2%)		Medical Loss Ratio	96.8%	96.7%	(0.1%)	
2.7%	3.9%	1.3%		Administrative Loss Ratio	3.2%	4.0%	0.8%	
1.6%	0.5%	1.1%		Operating Margin Ratio	(0.0%)	(0.7%)	0.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
94.4%	95.6%	1.2%		*MLR (excluding Directed Payments)	96.4%	96.7%	0.3%	
3.6%	3.9%	0.4%		*ALR (excluding Directed Payments)	3.6%	4.0%	0.4%	

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

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Consolidated Performance Actual vs. Budget: September 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	2.0	2.5	Medi-Cal	(1.6)	(4.5)	2.9
1.6	(0.7)	2.3	OCC	(0.4)	(2.9)	2.4
0.2	0.1	0.1	OneCare	0.3	0.2	0.2
0.4	0.2	0.2	PACE	1.5	0.6	0.9
6.7	**1.6**	**5.1**	**Operating**	**(0.2)**	**(6.6)**	**6.4**
(0.1)	1.3	(1.4)	Inv./Rental Inc, MCO tax	1.6	3.8	(2.1)
(0.1)	**1.3**	**(1.4)**	**Non-Operating**	**1.6**	**3.8**	**(2.1)**
6.5	**2.8**	**3.7**	**TOTAL**	**1.4**	**(2.9)**	**4.3**

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Consolidated Revenue & Expenses: September 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	504,952	253,445	13,020	771,417	14,529	1,594	380	787,920
REVENUES								
Capitation Revenue	205,618,162	$ 153,725,881	$ 25,256,176	$ 384,600,219	$ 33,838,826	$ 2,031,136	$ 3,195,605	$ 423,665,786
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	205,618,162	153,725,881	25,256,176	384,600,219	33,838,826	2,031,136	3,195,605	423,665,786
MEDICAL EXPENSES								
Provider Capitation	35,355,856	42,904,125	10,024,110	88,284,091	15,718,385	568,898		104,571,374
Facilities	26,484,667	24,444,036	1,995,805	52,924,507	5,218,341	424,551	663,998	59,231,397
Professional Claims	19,705,256	9,088,823	991,707	29,785,786	1,045,331	83,580	574,305	31,489,002
Prescription Drugs	20,185,684	25,497,346	4,059,085	49,742,116	6,060,626	572,749	336,642	56,712,133
MLTSS	35,451,562	2,952,202	2,101,998	40,505,761	1,316,522	6,551	(9,962)	41,818,873
Medical Management	2,220,019	1,401,099	295,108	3,916,227	1,037,676	45,693	896,068	5,895,664
Quality Incentives	999,481	587,162	37,818	1,624,461	217,785		4,750	1,846,996
Reinsurance & Other	57,300,392	46,467,706	19,604	103,787,702	140,596		107,138	104,035,436
Total Medical Expenses	197,702,918	153,342,498	19,525,235	370,570,651	30,755,263	1,702,022	2,572,939	405,600,875
Medical Loss Ratio	96.2%	99.8%	77.3%	96.4%	90.9%	83.8%	80.5%	95.7%
GROSS MARGIN	**7,915,244**	**383,383**	**5,730,941**	**14,029,568**	**3,083,563**	**329,114**	**622,666**	**18,064,911**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,708,925	709,779	85,181	136,741	7,640,626
Professional fees				308,388	5,333	16,000	247	329,968
Purchased services				759,832	91,512	7,945	5,123	864,411
Printing & Postage				124,779	55,587	17,122	50,556	248,044
Depreciation & Amortization				290,036			2,018	292,054
Other expenses				1,582,517	36,262		3,317	1,622,095
Indirect cost allocation & Occupancy				(276,737)	629,387	47,628	1,294	401,571
Total Administrative Expenses				9,497,740	1,527,860	173,875	199,295	11,398,770
Admin Loss Ratio				2.5%	4.5%	8.6%	6.2%	2.7%
INCOME (LOSS) FROM OPERATIONS				4,531,829	1,555,703	155,238	423,371	6,666,141
INVESTMENT INCOME								326,968
TOTAL MCO TAX				(458,114)				(458,114)
TOTAL GRANT INCOME				4,050				4,050
OTHER INCOME				20				20
CHANGE IN NET ASSETS				**$ 4,077,784**	**$ 1,555,703**	**$ 155,238**	**$ 423,371**	**$ 6,539,064**
BUDGETED CHANGE IN NET ASSETS				2,005,887	(732,384)	66,797	218,458	2,808,758
VARIANCE TO BUDGET - FAV (UNFAV)				$ 2,071,897	$ 2,288,087	$ 88,441	$ 204,913	$ 3,730,306

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Consolidated Revenue & Expenses: September 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,511,399	748,328	31,359	2,291,086	43,535	4,642	1,143	2,340,406
REVENUES								
Capitation Revenue	507,941,282	$ 358,323,813	$ 61,287,137	$ 927,552,232	$ 86,735,693	$ 5,894,250	$ 9,545,309	$ 1,029,727,484
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	507,941,282	358,323,813	61,287,137	927,552,232	86,735,693	5,894,250	9,545,309	1,029,727,484
MEDICAL EXPENSES								
Provider Capitation	106,771,293	127,614,354	31,978,120	266,363,767	37,868,048	1,605,202		305,837,018
Facilities	74,527,717	69,311,813	8,267,484	152,107,014	14,152,902	1,340,712	2,176,515	169,777,143
Professional Claims	58,440,916	27,409,072	3,358,510	89,208,497	2,933,800	237,750	1,686,202	94,066,249
Prescription Drugs	61,789,217	75,028,533	10,306,449	147,124,199	19,015,973	1,735,474	869,705	168,745,351
MLTSS	109,953,400	8,960,293	6,487,480	125,401,174	4,470,726	73,386	(9,873)	129,935,413
Medical Management	6,952,535	4,107,831	878,910	11,939,276	3,193,560	119,149	2,492,529	17,744,513
Quality Incentives	2,563,915	1,506,508	100,539	4,170,962	645,705		14,288	4,830,955
Reinsurance & Other	58,007,353	46,835,745	41,270	104,884,368	396,637		342,684	105,623,689
Total Medical Expenses	479,006,346	360,774,150	61,418,762	901,199,258	82,677,352	5,111,672	7,572,048	996,560,330
Medical Loss Ratio	94.3%	100.7%	100.2%	97.2%	95.3%	86.7%	79.3%	96.8%
GROSS MARGIN	**28,934,936**	**(2,450,336)**	**(131,626)**	**26,352,973**	**4,058,341**	**782,578**	**1,973,260**	**33,167,153**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				20,083,378	2,174,484	261,696	411,123	22,930,682
Professional fees				789,306	16,000	48,000	410	853,716
Purchased services				2,048,002	258,417	17,332	8,165	2,331,915
Printing & Postage				587,623	186,917	28,549	55,129	858,217
Depreciation & Amortization				876,556			6,125	882,681
Other expenses				4,281,277	114,834	205	8,838	4,405,154
Indirect cost allocation & Occupancy				(720,690)	1,736,371	117,998	9,513	1,143,191
Total Administrative Expenses				27,945,451	4,487,022	473,779	499,303	33,405,555
Admin Loss Ratio				3.0%	5.2%	8.0%	5.2%	3.2%
INCOME (LOSS) FROM OPERATIONS				(1,592,478)	(428,680)	308,799	1,473,958	(238,402)
INVESTMENT INCOME								3,343,146
TOTAL MCO TAX				(1,733,107)				(1,733,107)
TOTAL GRANT INCOME				10,913				10,913
OTHER INCOME				207				207
CHANGE IN NET ASSETS				**$ (3,314,465)**	**$ (428,680)**	**$ 308,799**	**$ 1,473,958**	**$ 1,382,757**
BUDGETED CHANGE IN NET ASSETS				(4,460,918)	(2,875,834)	156,121	558,311	(2,872,320)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,146,453	$ 2,447,154	$ 152,678	$ 915,647	$ 4,255,077

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Balance Sheet: As of September 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$284,740,279	Accounts Payable	$78,560,784
Investments	891,165,559	Medical Claims liability	905,686,994
Capitation receivable	326,098,561	Accrued Payroll Liabilities	16,648,281
Receivables - Other	49,066,605	Deferred Revenue	21,883,519
Prepaid expenses	6,185,523	Deferred Lease Obligations	152,624
		Capitation and Withholds	151,785,687
Total Current Assets	**1,557,256,527**	**Total Current Liabilities**	**1,174,717,888**
Capital Assets			
Furniture & Equipment	39,890,502		
Building/Leasehold Improvements	10,852,654		
505 City Parkway West	51,620,226		
	102,363,381		
Less: accumulated depreciation	(54,836,309)		
Capital assets, net	47,527,072	Other (than pensions) post employment benefits liability	25,938,821
Other Assets		Net Pension Liabilities	27,321,866
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,227,978,574**
Cash and Cash Equivalents	3,479,829		
Long-term Investments	583,746,489	**Deferred Inflows**	
Total Board-designated Assets	587,226,318	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
		Change in Assumptions	3,728,725
Total Other Assets	644,725,231	OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,249,508,830**	TNE	102,433,561
		Funds in Excess of TNE	924,080,492
Deferred Outflows		**TOTAL NET POSITION**	1,026,514,054
Contributions	1,047,297		
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,261,169,900**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,261,169,900**

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Board Designated Reserve and TNE Analysis: As of September 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,665,965				
	Tier 1 - MetLife	159,458,405				
	Tier 1 - Wells Capital	159,798,287				
Board-designated Reserve		479,922,656	319,097,426	499,753,563	160,825,231	(19,830,907)
TNE Requirement	Tier 2 - MetLife	107,303,662	102,433,561	102,433,561	4,870,100	4,870,100
	Consolidated:	**587,226,318**	**421,530,987**	**602,187,124**	**165,695,331**	**(14,960,806)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

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Our Mission

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

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UNAUDITED FINANCIAL STATEMENTS

September 30, 2020

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September 30, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $6.5 million, $3.7 million favorable to budget
- Operating surplus is $6.7 million, with a deficit in non-operating income of $0.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $1.4 million, $4.3 million favorable to budget
- Operating deficit is ($0.2) million, with a surplus in non-operating income of $1.6 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	2.0	2.5	Medi-Cal	(1.6)	(4.5)	2.9
1.6	(0.7)	2.3	OCC	(0.4)	(2.9)	2.4
0.2	0.1	0.1	OneCare	0.3	0.2	0.2
0.4	0.2	0.2	PACE	1.5	0.6	0.9
6.7	**1.6**	**5.1**	**Operating**	**(0.2)**	**(6.6)**	**6.4**
(0.1)	1.3	(1.4)	Inv./Rental Inc, MCO tax	1.6	3.8	(2.1)
(0.1)	**1.3**	**(1.4)**	**Non-Operating**	**1.6**	**3.8**	**(2.1)**
6.5	**2.8**	**3.7**	**TOTAL**	**1.4**	**(2.9)**	**4.3**

CalOptima
Financial Dashboard
For the Three Months Ended September 30, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	771,417	771,526	(109)	(0.0%)
OneCare Connect	14,529	14,080	449	3.2%
OneCare	1,594	1,378	216	15.7%
PACE	380	409	(29)	(7.1%)
Total	787,920	787,393	527	0.1%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 4,078	$ 2,006	$ 2,072	103.3%
OneCare Connect	1,556	(732)	2,288	312.4%
OneCare	155	67	88	132.4%
PACE	423	218	205	93.8%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	327	1,250	(923)	(73.8%)
Total	$ 6,539	$ 2,809	$ 3,730	132.8%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.4%	95.6%	(0.7)
OneCare Connect	90.9%	96.6%	5.7
OneCare	83.8%	87.9%	4.1

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,498	$ 10,759	$ 1,262	11.7%
OneCare Connect	1,528	1,606	78	4.9%
OneCare	174	137	(37)	(27.2%)
PACE	199	169	(31)	(18.1%)
Total	$ 11,399	$ 12,671	$ 1,272	10.0%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,067	1,161	94
OneCare Connect	187	210	23
OneCare	10	9	(1)
PACE	91	116	26
Total	1,354	1,496	142

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	723	665	58
OneCare Connect	78	67	11
OneCare	154	148	6
PACE	4	4	1
Total	959	883	76

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	2,291,086	2,289,171	1,915	0.1%
OneCare Connect	43,535	42,321	1,214	2.9%
OneCare	4,642	4,134	508	12.3%
PACE	1,143	1,215	(72)	(5.9%)
Total	2,340,406	2,336,841	3,565	0.2%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (3,314)	$ (4,461)	$ 1,146	25.7%
OneCare Connect	(429)	(2,876)	2,447	85.1%
OneCare	309	156	153	97.8%
PACE	1,474	558	916	164.0%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	3,343	3,750	(407)	(10.9%)
Total	$ 1,383	$ (2,873)	$ 4,256	148.1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.2%	96.7%	(0.4)
OneCare Connect	95.3%	97.4%	2.1
OneCare	86.7%	88.8%	2.0

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 27,945	$ 32,693	$ 4,747	14.5%
OneCare Connect	4,487	4,869	382	7.8%
OneCare	474	413	(61)	(14.6%)
PACE	499	479	(20)	(4.2%)
Total	$ 33,406	$ 38,454	$ 5,048	13.1%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	3,271	3,482	211
OneCare Connect	575	629	55
OneCare	31	28	(3)
PACE	269	349	80
Total	4,146	4,488	343

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	700	657	43
OneCare Connect	76	67	9
OneCare	152	148	4
PACE	4	3	1
Total	933	876	56

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended September 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	787,920		787,393		527	
REVENUE						
Medi-Cal	$ 384,600,219	$ 498.56	$ 290,665,728	$ 376.74	$ 93,934,491	$ 121.82
OneCare Connect	33,838,826	2,329.05	25,858,218	1,836.52	7,980,608	492.53
OneCare	2,031,136	1,274.24	1,686,604	1,223.95	344,532	50.29
PACE	3,195,605	8,409.49	3,324,251	8,127.75	(128,646)	281.74
Total Operating Revenue	423,665,786	537.70	321,534,801	408.35	102,130,985	129.35
MEDICAL EXPENSES						
Medi-Cal	370,570,651	480.38	277,900,422	360.20	(92,670,229)	(120.18)
OneCare Connect	30,755,263	2,116.82	24,984,620	1,774.48	(5,770,643)	(342.34)
OneCare	1,702,022	1,067.77	1,483,083	1,076.26	(218,939)	8.49
PACE	2,572,939	6,770.89	2,937,020	7,180.98	364,081	410.09
Total Medical Expenses	405,600,875	514.77	307,305,145	390.28	(98,295,730)	(124.49)
GROSS MARGIN	18,064,911	22.93	14,229,656	18.07	3,835,255	4.86
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,640,626	9.70	7,916,033	10.05	275,407	0.35
Professional fees	329,968	0.42	369,342	0.47	39,374	0.05
Purchased services	864,411	1.10	1,277,201	1.62	412,790	0.52
Printing & Postage	248,044	0.31	569,734	0.72	321,690	0.41
Depreciation & Amortization	292,054	0.37	460,570	0.58	168,516	0.21
Other expenses	1,622,095	2.06	1,693,040	2.15	70,945	0.09
Indirect cost allocation & Occupancy expense	401,571	0.51	384,978	0.49	(16,593)	(0.02)
Total Administrative Expenses	11,398,770	14.47	12,670,898	16.09	1,272,128	1.62
INCOME (LOSS) FROM OPERATIONS	6,666,141	8.46	1,558,758	1.98	5,107,383	6.48
INVESTMENT INCOME						
Interest income	1,129,930	1.43	1,250,000	1.59	(120,070)	(0.16)
Realized gain/(loss) on investments	656,499	0.83	-	-	656,499	0.83
Unrealized gain/(loss) on investments	(1,459,462)	(1.85)	-	-	(1,459,462)	(1.85)
Total Investment Income	326,968	0.41	1,250,000	1.59	(923,032)	(1.18)
TOTAL MCO TAX	(458,114)	(0.58)	-	-	(458,114)	(0.58)
TOTAL GRANT INCOME	4,050	0.01	-	-	4,050	0.01
OTHER INCOME	20	-	-	-	20	-
CHANGE IN NET ASSETS	**6,539,064**	**8.30**	**2,808,758**	**3.57**	**3,730,306**	**4.73**
MEDICAL LOSS RATIO	**95.7%**		**95.6%**		**(0.2%)**	
ADMINISTRATIVE LOSS RATIO	**2.7%**		**3.9%**		**1.3%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	2,340,406		2,336,841		3,565	
REVENUE						
Medi-Cal	$ 927,552,232	$ 404.85	$ 864,798,713	$ 377.78	$ 62,753,519	$ 27.07
OneCare Connect	86,735,693	1,992.32	77,835,247	1,839.16	8,900,446	153.16
OneCare	5,894,250	1,269.77	5,068,077	1,225.95	826,173	43.82
PACE	9,545,309	8,351.10	9,878,262	8,130.26	(332,953)	220.84
Total Operating Revenue	1,029,727,484	439.98	957,580,299	409.78	72,147,185	30.20
MEDICAL EXPENSES						
Medi-Cal	901,199,258	393.35	836,567,000	365.45	(64,632,258)	(27.90)
OneCare Connect	82,677,352	1,899.10	75,842,530	1,792.08	(6,834,822)	(107.02)
OneCare	5,111,672	1,101.18	4,498,687	1,088.22	(612,985)	(12.96)
PACE	7,572,048	6,624.71	8,840,625	7,276.23	1,268,577	651.52
Total Medical Expenses	996,560,330	425.81	925,748,842	396.15	(70,811,488)	(29.66)
GROSS MARGIN	33,167,153	14.17	31,831,457	13.63	1,335,696	0.54
ADMINISTRATIVE EXPENSES						
Salaries and benefits	22,930,682	9.80	24,183,758	10.35	1,253,076	0.55
Professional fees	853,716	0.36	1,108,026	0.47	254,310	0.11
Purchased services	2,331,915	1.00	3,831,604	1.64	1,499,689	0.64
Printing & Postage	858,217	0.37	1,709,202	0.73	850,985	0.36
Depreciation & Amortization	882,681	0.38	1,381,710	0.59	499,029	0.21
Other expenses	4,405,154	1.88	5,082,726	2.18	677,572	0.30
Indirect cost allocation & Occupancy expense	1,143,191	0.49	1,156,751	0.50	13,560	0.01
Total Administrative Expenses	33,405,555	14.27	38,453,777	16.46	5,048,222	2.19
INCOME (LOSS) FROM OPERATIONS	(238,402)	(0.10)	(6,622,320)	(2.83)	6,383,918	2.73
INVESTMENT INCOME						
Interest income	3,676,990	1.57	3,750,000	1.60	(73,010)	(0.03)
Realized gain/(loss) on investments	2,318,301	0.99	-	-	2,318,301	0.99
Unrealized gain/(loss) on investments	(2,652,145)	(1.13)	-	-	(2,652,145)	(1.13)
Total Investment Income	3,343,146	1.43	3,750,000	1.60	(406,854)	(0.17)
TOTAL MCO TAX	(1,733,107)	(0.74)	-	-	(1,733,107)	(0.74)
TOTAL GRANT INCOME	10,913	-	-	-	10,913	-
OTHER INCOME	207	-	-	-	207	-
CHANGE IN NET ASSETS	**1,382,757**	**0.59**	**(2,872,320)**	**(1.23)**	**4,255,077**	**1.82**
MEDICAL LOSS RATIO	**96.8%**		**96.7%**		**(0.1%)**	
ADMINISTRATIVE LOSS RATIO	**3.2%**		**4.0%**		**0.8%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended September 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	504,952	253,445	13,020	771,417	14,529	1,594	380	787,920
REVENUES								
Capitation Revenue	205,618,162	$ 153,725,881	$ 25,256,176	$ 384,600,219	$ 33,838,826	$ 2,031,136	$ 3,195,605	$ 423,665,786
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	205,618,162	153,725,881	25,256,176	384,600,219	33,838,826	2,031,136	3,195,605	423,665,786
MEDICAL EXPENSES								
Provider Capitation	35,355,856	42,904,125	10,024,110	88,284,091	15,718,385	568,898		104,571,374
Facilities	26,484,667	24,444,036	1,995,805	52,924,507	5,218,341	424,551	663,998	59,231,397
Professional Claims	19,705,256	9,088,823	991,707	29,785,786	1,045,331	83,580	574,305	31,489,002
Prescription Drugs	20,185,684	25,497,346	4,059,085	49,742,116	6,060,626	572,749	336,642	56,712,133
MLTSS	35,451,562	2,952,202	2,101,998	40,505,761	1,316,522	6,551	(9,962)	41,818,873
Medical Management	2,220,019	1,401,099	295,108	3,916,227	1,037,676	45,693	896,068	5,895,664
Quality Incentives	999,481	587,162	37,818	1,624,461	217,785		4,750	1,846,996
Reinsurance & Other	57,300,392	46,467,706	19,604	103,787,702	140,596		107,138	104,035,436
Total Medical Expenses	197,702,918	153,342,498	19,525,235	370,570,651	30,755,263	1,702,022	2,572,939	405,600,875
Medical Loss Ratio	96.2%	99.8%	77.3%	96.4%	90.9%	83.8%	80.5%	95.7%
GROSS MARGIN	**7,915,244**	**383,383**	**5,730,941**	**14,029,568**	**3,083,563**	**329,114**	**622,666**	**18,064,911**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,708,925	709,779	85,181	136,741	7,640,626
Professional fees				308,388	5,333	16,000	247	329,968
Purchased services				759,832	91,512	7,945	5,123	864,411
Printing & Postage				124,779	55,587	17,122	50,556	248,044
Depreciation & Amortization				290,036			2,018	292,054
Other expenses				1,582,517	36,262		3,317	1,622,095
Indirect cost allocation & Occupancy				(276,737)	629,387	47,628	1,294	401,571
Total Administrative Expenses				9,497,740	1,527,860	173,875	199,295	11,398,770
Admin Loss Ratio				2.5%	4.5%	8.6%	6.2%	2.7%
INCOME (LOSS) FROM OPERATIONS				4,531,829	1,555,703	155,238	423,371	6,666,141
INVESTMENT INCOME								326,968
TOTAL MCO TAX				(458,114)				(458,114)
TOTAL GRANT INCOME				4,050				4,050
OTHER INCOME				20				20
CHANGE IN NET ASSETS				**$ 4,077,784**	**$ 1,555,703**	**$ 155,238**	**$ 423,371**	**$ 6,539,064**
BUDGETED CHANGE IN NET ASSETS				2,005,887	(732,384)	66,797	218,458	2,808,758
VARIANCE TO BUDGET - FAV (UNFAV)				$ 2,071,897	$ 2,288,087	$ 88,441	$ 204,913	$ 3,730,306

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ended September 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,511,399	748,328	31,359	2,291,086	43,535	4,642	1,143	2,340,406
REVENUES								
Capitation Revenue	507,941,282	$ 358,323,813	$ 61,287,137	$ 927,552,232	$ 86,735,693	$ 5,894,250	$ 9,545,309	$ 1,029,727,484
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	507,941,282	358,323,813	61,287,137	927,552,232	86,735,693	5,894,250	9,545,309	1,029,727,484
MEDICAL EXPENSES								
Provider Capitation	106,771,293	127,614,354	31,978,120	266,363,767	37,868,048	1,605,202		305,837,018
Facilities	74,527,717	69,311,813	8,267,484	152,107,014	14,152,902	1,340,712	2,176,515	169,777,143
Professional Claims	58,440,916	27,409,072	3,358,510	89,208,497	2,933,800	237,750	1,686,202	94,066,249
Prescription Drugs	61,789,217	75,028,533	10,306,449	147,124,199	19,015,973	1,735,474	869,705	168,745,351
MLTSS	109,953,400	8,960,293	6,487,480	125,401,174	4,470,726	73,386	(9,873)	129,935,413
Medical Management	6,952,535	4,107,831	878,910	11,939,276	3,193,560	119,149	2,492,529	17,744,513
Quality Incentives	2,563,915	1,506,508	100,539	4,170,962	645,705		14,288	4,830,955
Reinsurance & Other	58,007,353	46,835,745	41,270	104,884,368	396,637		342,684	105,623,689
Total Medical Expenses	479,006,346	360,774,150	61,418,762	901,199,258	82,677,352	5,111,672	7,572,048	996,560,330
Medical Loss Ratio	94.3%	100.7%	100.2%	97.2%	95.3%	86.7%	79.3%	96.8%
GROSS MARGIN	**28,934,936**	**(2,450,336)**	**(131,626)**	**26,352,973**	**4,058,341**	**782,578**	**1,973,260**	**33,167,153**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				20,083,378	2,174,484	261,696	411,123	22,930,682
Professional fees				789,306	16,000	48,000	410	853,716
Purchased services				2,048,002	258,417	17,332	8,165	2,331,915
Printing & Postage				587,623	186,917	28,549	55,129	858,217
Depreciation & Amortization				876,556			6,125	882,681
Other expenses				4,281,277	114,834	205	8,838	4,405,154
Indirect cost allocation & Occupancy				(720,690)	1,736,371	117,998	9,513	1,143,191
Total Administrative Expenses				27,945,451	4,487,022	473,779	499,303	33,405,555
Admin Loss Ratio				3.0%	5.2%	8.0%	5.2%	3.2%
INCOME (LOSS) FROM OPERATIONS				(1,592,478)	(428,680)	308,799	1,473,958	(238,402)
INVESTMENT INCOME								3,343,146
TOTAL MCO TAX				(1,733,107)				(1,733,107)
TOTAL GRANT INCOME				10,913				10,913
OTHER INCOME				207				207
CHANGE IN NET ASSETS				**$ (3,314,465)**	**$ (428,680)**	**$ 308,799**	**$ 1,473,958**	**$ 1,382,757**
BUDGETED CHANGE IN NET ASSETS				(4,460,918)	(2,875,834)	156,121	558,311	(2,872,320)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,146,453	$ 2,447,154	$ 152,678	$ 915,647	$ 4,255,077

CalOptima - Consolidated
Financial Highlights
For the Three Months Ended September 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
787,920	787,393	527	0.1%	Member Months	2,340,406	2,336,841	3,565	0.2%
423,665,786	321,534,801	102,130,985	31.8%	Revenues	1,029,727,484	957,580,299	72,147,185	7.5%
405,600,875	307,305,145	(98,295,730)	(32.0%)	Medical Expenses	996,560,330	925,748,842	(70,811,488)	(7.6%)
11,398,770	12,670,898	1,272,128	10.0%	Administrative Expenses	33,405,555	38,453,777	5,048,222	13.1%
6,666,141	**1,558,758**	**5,107,383**	**327.7%**	**Operating Margin**	**(238,402)**	**(6,622,320)**	**6,383,918**	**96.4%**
(127,077)	1,250,000	(1,377,077)	(110.2%)	Non Operating Income (Loss)	1,621,158	3,750,000	(2,128,842)	(56.8%)
6,539,064	**2,808,758**	**3,730,306**	**132.8%**	**Change in Net Assets**	**1,382,757**	**(2,872,320)**	**4,255,077**	**148.1%**
95.7%	95.6%	(0.2%)		Medical Loss Ratio	96.8%	96.7%	(0.1%)	
2.7%	3.9%	1.3%		Administrative Loss Ratio	3.2%	4.0%	0.8%	
1.6%	0.5%	1.1%		Operating Margin Ratio	(0.0%)	(0.7%)	0.7%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
94.4%	95.6%	1.2%		*MLR (excluding Directed Payments)	96.4%	96.7%	0.3%	
3.6%	3.9%	0.4%		*ALR (excluding Directed Payments)	3.6%	4.0%	0.4%	

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

CalOptima - Consolidated
Enrollment Summary
For the Three Months Ended September 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
113,044	110,857	2,187	2.0%	SPD	338,554	332,449	6,105	1.8%
518	485	33	6.8%	BCCTP	1,538	1,467	71	4.8%
289,351	306,002	(16,651)	(5.4%)	TANF Child	869,380	905,027	(35,647)	(3.9%)
97,148	92,042	5,106	5.5%	TANF Adult	287,432	272,323	15,109	5.5%
4,891	3,509	1,382	39.4%	LTC	14,495	10,521	3,974	37.8%
253,445	246,699	6,746	2.7%	MCE	748,328	731,588	16,740	2.3%
13,020	11,932	1,088	9.1%	WCM	31,359	35,796	(4,437)	(12.4%)
771,417	**771,526**	**(109)**	**(0.0%)**	**Medi-Cal Total**	**2,291,086**	**2,289,171**	**1,915**	**0.1%**
14,529	**14,080**	**449**	**3.2%**	**OneCare Connect**	**43,535**	**42,321**	**1,214**	**2.9%**
1,594	**1,378**	**216**	**15.7%**	**OneCare**	**4,642**	**4,134**	**508**	**12.3%**
380	**409**	**(29)**	**(7.1%)**	**PACE**	**1,143**	**1,215**	**(72)**	**(5.9%)**
787,920	**787,393**	**527**	**0.1%**	**CalOptima Total**	**2,340,406**	**2,336,841**	**3,565**	**0.2%**
				Enrollment (by Network)				
174,042	172,152	1,890	1.1%	HMO	517,859	511,080	6,779	1.3%
215,806	222,556	(6,750)	(3.0%)	PHC	646,784	659,794	(13,010)	(2.0%)
181,767	188,748	(6,981)	(3.7%)	Shared Risk Group	547,825	557,613	(9,788)	(1.8%)
199,802	188,070	11,732	6.2%	Fee for Service	578,618	560,684	17,934	3.2%
771,417	**771,526**	**(109)**	**(0.0%)**	**Medi-Cal Total**	**2,291,086**	**2,289,171**	**1,915**	**0.1%**
14,529	**14,080**	**449**	**3.2%**	**OneCare Connect**	**43,535**	**42,321**	**1,214**	**2.9%**
1,594	**1,378**	**216**	**15.7%**	**OneCare**	**4,642**	**4,134**	**508**	**12.3%**
380	**409**	**(29)**	**(7.1%)**	**PACE**	**1,143**	**1,215**	**(72)**	**(5.9%)**
787,920	**787,393**	**527**	**0.1%**	**CalOptima Total**	**2,340,406**	**2,336,841**	**3,565**	**0.2%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536	10,583	10,588										31,707	31,067	640
BCCTP	1	1	1										3	3	0
TANF Child	54,644	55,088	55,115										164,847	170,785	(5,938)
TANF Adult	29,033	29,687	30,001										88,721	85,980	2,741
LTC	(1)	402	197										598	6	592
MCE	74,441	75,955	76,054										226,450	217,104	9,346
WCM	1,721	1,726	2,086										5,533	6,135	(602)
Total	**170,375**	**173,442**	**174,042**										**517,859**	**511,080**	**6,779**
PHCs															
SPD	7,145	7,205	6,855										21,205	21,068	137
BCCTP													-		0
TANF Child	149,810	151,008	148,874										449,692	467,537	(17,845)
TANF Adult	11,688	12,097	12,071										35,856	33,564	2,292
LTC		158	81										239	3	236
MCE	39,815	40,711	39,935										120,461	116,073	4,388
WCM	5,625	5,716	7,990										19,331	21,549	(2,218)
Total	**214,083**	**216,895**	**215,806**										**646,784**	**659,794**	**(13,010)**
Shared Risk Groups															
SPD	10,264	10,312	10,068										30,644	30,520	124
BCCTP													-		0
TANF Child	58,289	58,687	57,269										174,245	188,022	(13,777)
TANF Adult	28,914	29,648	29,235										87,797	86,264	1,533
LTC	1	365	178										544	6	538
MCE	82,747	84,907	83,063										250,717	247,723	2,994
WCM	924	1,000	1,954										3,878	5,078	(1,200)
Total	**181,139**	**184,919**	**181,767**										**547,825**	**557,613**	**(9,788)**
Fee for Service (Dual)															
SPD	74,615	75,198	75,269										225,082	220,276	4,806
BCCTP	12	17	18										47	51	(4)
TANF Child	1	1	1										3	6	(3)
TANF Adult	909	1,266	994										3,169	2,894	275
LTC	3,079	4,461	3,855										11,395	9,477	1,918
MCE	1,658	1,859	1,948										5,465	4,137	1,328
WCM	13	17	16										46	39	7
Total	**80,287**	**82,819**	**82,101**										**245,207**	**236,880**	**8,327**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822	10,264										29,916	29,518	398
BCCTP	497	492	499										1,488	1,413	75
TANF Child	25,494	27,007	28,092										80,593	78,677	1,916
TANF Adult	23,028	24,014	24,847										71,889	63,621	8,268
LTC	351	788	580										1,719	1,029	690
MCE	45,498	47,292	52,445										145,235	146,551	(1,316)
WCM	791	806	974										2,571	2,995	(424)
Total	**105,489**	**110,221**	**117,701**										**333,411**	**323,804**	**9,607**
SPD	112,390	113,120	113,044										338,554	332,449	6,105
BCCTP	510	510	518										1,538	1,467	71
TANF Child	288,238	291,791	289,351										869,380	905,027	(35,647)
TANF Adult	93,572	96,712	97,148										287,432	272,323	15,109
LTC	3,430	6,174	4,891										14,495	10,521	3,974
MCE	244,159	250,724	253,445										748,328	731,588	16,740
WCM	9,074	9,265	13,020										31,359	35,796	(4,437)
Total Medi-Cal MM	**751,373**	**768,296**	**771,417**										**2,291,086**	**2,289,171**	**1,915**
OneCare Connect	**14,465**	**14,541**	**14,529**										**43,535**	**42,321**	**1,214**
OneCare	**1,525**	**1,523**	**1,594**										**4,642**	**4,134**	**508**
PACE	**382**	**381**	**380**										**1,143**	**1,215**	**(72)**
Grand Total	**767,745**	**784,741**	**787,920**										**2,340,406**	**2,336,841**	**3,565**

ENROLLMENT:

Overall, September enrollment was 787,920

- Favorable to budget 527 or 0.1%
- Increased 3,179 or 0.4% from prior month (PM) (August 2020)
- Increased 59,846 or 8.2% from prior year (PY) (September 2019)

Medi-Cal enrollment was 771,417

- Unfavorable to budget 109 or 0.0%
  - Temporary Assistance for Needy Families (TANF) unfavorable 11,545
  - Medi-Cal Expansion (MCE) favorable 6,746
  - Seniors and Persons with Disabilities (SPD) favorable 2,187
  - Long-Term Care (LTC) favorable 1,382
  - Whole Child Model (WCM) favorable 1,088 due to retroactive enrollment of 2,544
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 33
- Increased 3,121 from PM

OneCare Connect enrollment was 14,529

- Favorable to budget 449 or 3.2%
- Decreased 12 from PM

OneCare enrollment was 1,594

- Favorable to budget 216 or 15.7%
- Increased 71 from PM

PACE enrollment was 380

- Unfavorable to budget 29 or 7.1%
- Decreased 1 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
771,417	**771,526**	**(109)**	**(0.0%)**	**Member Months**	**2,291,086**	**2,289,171**	**1,915**	**0.1%**
				Revenues				
384,600,219	290,665,728	93,934,491	32.3%	Capitation Revenue	927,552,232	864,798,713	62,753,519	7.3%
-	-	-	0.0%	Other Income	-	-	-	0.0%
384,600,219	**290,665,728**	**93,934,491**	**32.3%**	**Total Operating Revenue**	**927,552,232**	**864,798,713**	**62,753,519**	**7.3%**
				Medical Expenses				
89,908,552	98,188,911	8,280,359	8.4%	Provider Capitation	270,534,730	291,261,086	20,726,356	7.1%
52,924,507	56,884,677	3,960,170	7.0%	Facilities Claims	152,107,014	172,122,810	20,015,796	11.6%
29,785,786	32,192,550	2,406,764	7.5%	Professional Claims	89,208,497	97,554,419	8,345,922	8.6%
49,742,116	45,696,304	(4,045,812)	(8.9%)	Prescription Drugs	147,124,199	138,569,063	(8,555,136)	(6.2%)
40,505,761	39,445,674	(1,060,087)	(2.7%)	MLTSS	125,401,174	120,637,381	(4,763,793)	(3.9%)
3,916,227	4,888,298	972,071	19.9%	Medical Management	11,939,276	14,610,221	2,670,945	18.3%
103,787,702	604,008	(103,183,694)	(17083.2%)	Reinsurance & Other	104,884,368	1,812,020	(103,072,348)	(5688.3%)
370,570,651	**277,900,422**	**(92,670,229)**	**(33.3%)**	**Total Medical Expenses**	**901,199,258**	**836,567,000**	**(64,632,258)**	**(7.7%)**
14,029,568	**12,765,306**	**1,264,262**	**9.9%**	**Gross Margin**	**26,352,973**	**28,231,713**	**(1,878,740)**	**(6.7%)**
				Administrative Expenses				
6,708,925	6,933,169	224,244	3.2%	Salaries, Wages & Employee Benefits	20,083,378	21,209,436	1,126,058	5.3%
308,388	313,093	4,705	1.5%	Professional Fees	789,306	939,279	149,973	16.0%
759,832	1,146,263	386,431	33.7%	Purchased Services	2,048,002	3,438,790	1,390,788	40.4%
124,779	443,433	318,654	71.9%	Printing and Postage	587,623	1,330,299	742,676	55.8%
290,036	458,500	168,464	36.7%	Depreciation & Amortization	876,556	1,375,500	498,944	36.3%
1,582,517	1,673,105	90,588	5.4%	Other Operating Expenses	4,281,277	5,021,867	740,590	14.7%
(276,737)	(208,144)	68,593	33.0%	Indirect Cost Allocation, Occupancy Expense	(720,690)	(622,540)	98,150	15.8%
9,497,740	**10,759,419**	**1,261,679**	**11.7%**	**Total Administrative Expenses**	**27,945,451**	**32,692,631**	**4,747,180**	**14.5%**
				Operating Tax				
12,010,636	14,940,538	(2,929,902)	(19.6%)	Tax Revenue	35,673,143	44,337,079	(8,663,936)	(19.5%)
12,468,750	14,940,538	2,471,788	16.5%	Premium Tax Expense	37,406,250	44,337,079	6,930,829	15.6%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
(458,114)	-	(458,114)	**0.0%**	**Total Net Operating Tax**	(1,733,107)	-	(1,733,107)	**0.0%**
				Grant Income				
35,409	-	35,409	0.0%	Grant Revenue	86,490	-	86,490	0.0%
22,950	-	(22,950)	0.0%	Grant expense - Service Partner	61,838	-	(61,838)	0.0%
8,409	-	(8,409)	0.0%	Grant expense - Administrative	13,740	-	(13,740)	0.0%
4,050	-	4,050	**0.0%**	**Total Grant Income**	10,913	-	10,913	**0.0%**
20	**-**	**20**	**0.0%**	**Other income**	**207**	**-**	**207**	**0.0%**
4,077,784	**2,005,887**	**2,071,897**	**103.3%**	**Change in Net Assets**	**(3,314,465)**	**(4,460,918)**	**1,146,453**	**25.7%**
96.4%	***95.6%***	***(0.7%)***	***(0.8%)***	***Medical Loss Ratio***	***97.2%***	***96.7%***	***(0.4%)***	***(0.4%)***
2.5%	***3.7%***	***1.2%***	***33.3%***	***Admin Loss Ratio***	***3.0%***	***3.8%***	***0.8%***	***20.3%***

MEDI-CAL INCOME STATEMENT – SEPTEMBER MONTH:

REVENUES of $384.6 million are favorable to budget $93.9 million driven by:

- Unfavorable volume related variance of $41,065
- Favorable price related variance of $94.0 million
  - $103.2 million of fiscal year (FY) 2019 hospital Directed Payments (DP)
  - $13.8 million for Coordinated Care Initiative (CCI) revenue
  - $4.9 million of WCM revenue due to retroactive enrollment
  - Offset by $19.1 million of Proposition 56 risk corridor

MEDICAL EXPENSES of $370.6 million are unfavorable to budget $92.7 million driven by:

- Favorable volume related variance of $39,261
- Unfavorable price related variance of $92.7 million
  - Reinsurance & Other expense unfavorable variance of $103.2 million due to FY 2019 DP
  - Prescription Drugs expense unfavorable variance of $4.1 million
  - Managed Long Term Services and Supports (MLTSS) expense unfavorable variance of $1.1 million
  - Offset by Provider Capitation expense favorable variance of $8.3 million due to decreased utilization during COVID-19 pandemic
  - Facilities Claims expense favorable variance of $4.0 million due to decreased utilization during COVID-19 pandemic
  - Professional Claims expense favorable variance of $2.4 million due to decreased utilization during COVID-19 pandemic

ADMINISTRATIVE EXPENSES of $9.5 million are favorable to budget $1.3 million driven by:

- Salaries & Benefit expense favorable to budget $0.2 million
- Other Non-Salary expense favorable to budget $1.0 million

CHANGE IN NET ASSETS is $4.1 million for the month, favorable to budget $2.1 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,529	**14,080**	**449**	**3.2%**	**Member Months**	**43,535**	**42,321**	**1,214**	**2.9%**
				Revenues				
3,003,230	2,718,375	284,855	10.5%	Medi-Cal Capitation Revenue	9,832,322	8,170,775	1,661,547	20.3%
24,987,481	17,918,703	7,068,778	39.4%	Medicare Capitation Revenue Part C	60,457,027	53,968,738	6,488,289	12.0%
5,848,115	5,221,140	626,975	12.0%	Medicare Capitation Revenue Part D	16,446,344	15,695,734	750,610	4.8%
-	-	-	0.0%	Other Income	-	-	-	0.0%
33,838,826	**25,858,218**	**7,980,608**	**30.9%**	**Total Operating Revenue**	**86,735,693**	**77,835,247**	**8,900,446**	**11.4%**
				Medical Expenses				
15,936,170	11,425,929	(4,510,241)	(39.5%)	Provider Capitation	38,513,753	34,448,634	(4,065,119)	(11.8%)
5,218,341	3,966,436	(1,251,905)	(31.6%)	Facilities Claims	14,152,902	12,036,485	(2,116,417)	(17.6%)
1,045,331	918,369	(126,962)	(13.8%)	Ancillary	2,933,800	2,803,446	(130,354)	(4.6%)
1,316,522	1,513,580	197,058	13.0%	MLTSS	4,470,726	4,657,678	186,952	4.0%
6,060,626	5,758,175	(302,451)	(5.3%)	Prescription Drugs	19,015,973	17,617,208	(1,398,765)	(7.9%)
1,037,676	1,190,500	152,824	12.8%	Medical Management	3,193,560	3,635,020	441,460	12.1%
140,596	211,631	71,035	33.6%	Other Medical Expenses	396,637	644,059	247,422	38.4%
30,755,263	**24,984,620**	**(5,770,643)**	**(23.1%)**	**Total Medical Expenses**	**82,677,352**	**75,842,530**	**(6,834,822)**	**(9.0%)**
3,083,563	**873,598**	**2,209,965**	**253.0%**	**Gross Margin**	**4,058,341**	**1,992,717**	**2,065,624**	**103.7%**
				Administrative Expenses				
709,779	786,617	76,838	9.8%	Salaries, Wages & Employee Benefits	2,174,484	2,409,462	234,978	9.8%
5,333	40,083	34,750	86.7%	Professional Fees	16,000	120,249	104,249	86.7%
91,512	103,412	11,900	11.5%	Purchased Services	258,417	310,236	51,819	16.7%
55,587	106,517	50,930	47.8%	Printing and Postage	186,917	319,551	132,634	41.5%
36,262	15,861	(20,401)	(128.6%)	Other Operating Expenses	114,834	48,577	(66,257)	(136.4%)
629,387	553,492	(75,895)	(13.7%)	Indirect Cost Allocation	1,736,371	1,660,476	(75,895)	(4.6%)
1,527,860	**1,605,982**	**78,122**	**4.9%**	**Total Administrative Expenses**	**4,487,022**	**4,868,551**	**381,529**	**7.8%**
1,555,703	**(732,384)**	**2,288,087**	**312.4%**	**Change in Net Assets**	**(428,680)**	**(2,875,834)**	**2,447,154**	**85.1%**
90.9%	***96.6%***	***5.7%***	***5.9%***	***Medical Loss Ratio***	***95.3%***	***97.4%***	***2.1%***	***2.2%***
4.5%	***6.2%***	***1.7%***	***27.3%***	***Admin Loss Ratio***	***5.2%***	***6.3%***	***1.1%***	***17.3%***

ONECARE CONNECT INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES of $33.8 million are favorable to budget $8.0 million driven by:

- Favorable volume related variance of $0.8 million
- Favorable price related variance of $7.2 million due to calendar year (CY) 2018 Quality Withhold (QW) payment received from the Center for Medicare & Medicaid Services (CMS)

MEDICAL EXPENSES of $30.8 million are unfavorable to budget $5.8 million driven by:

- Unfavorable volume related variance of $0.8 million
- Unfavorable price related variance of $5.0 million
  - Provider Capitation expense unfavorable variance of $4.1 million due to CY 2018 QW payable to the Health Networks (HN)
  - Facilities Claims expense unfavorable variance of $1.1 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is $1.6 million, favorable to budget $2.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,594	**1,378**	**216**	**15.7%**	**Member Months**	**4,642**	**4,134**	**508**	**12.3%**
				Revenues				
1,404,969	1,149,468	255,501	22.2%	Medicare Part C revenue	4,042,025	3,456,519	585,506	16.9%
626,167	537,136	89,031	16.6%	Medicare Part D revenue	1,852,225	1,611,558	240,667	14.9%
2,031,136	**1,686,604**	**344,532**	**20.4%**	**Total Operating Revenue**	**5,894,250**	**5,068,077**	**826,173**	**16.3%**
				Medical Expenses				
568,898	445,091	(123,807)	(27.8%)	Provider Capitation	1,605,202	1,338,405	(266,797)	(19.9%)
424,551	451,025	26,474	5.9%	Inpatient	1,340,712	1,367,384	26,672	2.0%
83,580	42,364	(41,216)	(97.3%)	Ancillary	237,750	128,611	(109,139)	(84.9%)
6,551	25,059	18,508	73.9%	Skilled Nursing Facilities	73,386	76,849	3,463	4.5%
572,749	476,102	(96,647)	(20.3%)	Prescription Drugs	1,735,474	1,455,241	(280,233)	(19.3%)
45,693	43,442	(2,251)	(5.2%)	Medical Management	119,149	132,197	13,048	9.9%
1,702,022	**1,483,083**	**(218,939)**	**(14.8%)**	**Total Medical Expenses**	**5,111,672**	**4,498,687**	**(612,985)**	**(13.6%)**
329,114	**203,521**	**125,593**	**61.7%**	**Gross Margin**	**782,578**	**569,390**	**213,188**	**37.4%**
				Administrative Expenses				
85,181	67,168	(18,013)	(26.8%)	Salaries, wages & employee benefits	261,696	204,601	(57,095)	(27.9%)
16,000	16,000	-	0.0%	Professional fees	48,000	48,000	-	0.0%
7,945	9,750	1,805	18.5%	Purchased services	17,332	29,250	11,918	40.7%
17,122	8,084	(9,038)	(111.8%)	Printing and postage	28,549	24,252	(4,297)	(17.7%)
-	537	537	100.0%	Other operating expenses	205	1,611	1,406	87.3%
47,628	35,185	(12,443)	(35.4%)	Indirect cost allocation, occupancy expens	117,998	105,555	(12,443)	(11.8%)
173,875	**136,724**	**(37,151)**	**(27.2%)**	**Total Administrative Expenses**	**473,779**	**413,269**	**(60,510)**	**(14.6%)**
155,238	**66,797**	**88,441**	**132.4%**	**Change in Net Assets**	**308,799**	**156,121**	**152,678**	**97.8%**
83.8%	***87.9%***	***4.1%***	***4.7%***	***Medical Loss Ratio***	***86.7%***	***88.8%***	***2.0%***	***2.3%***
8.6%	***8.1%***	***(0.5%)***	***(5.6%)***	***Admin Loss Ratio***	***8.0%***	***8.2%***	***0.1%***	***1.4%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
380	**409**	**(29)**	**(7.1%)**	**Member Months**	**1,143**	**1,215**	**(72)**	**-5.9%**
				Revenues				
2,389,641	2,574,503	(184,862)	(7.2%)	Medi-Cal Capitation Revenue	7,192,241	7,648,671	(456,430)	(6.0%)
619,175	604,107	15,068	2.5%	Medicare Part C Revenue	1,905,408	1,797,105	108,303	6.0%
186,790	145,641	41,149	28.3%	Medicare Part D Revenue	447,660	432,486	15,174	3.5%
3,195,605	**3,324,251**	**(128,646)**	**(3.9%)**	**Total Operating Revenue**	**9,545,309**	**9,878,262**	**(332,953)**	**(3.4%)**
				Medical Expenses				
896,068	962,428	66,360	6.9%	Medical Management	2,492,529	2,873,874	381,345	13.3%
663,998	759,990	95,992	12.6%	Facilities Claims	2,176,515	2,291,019	114,504	5.0%
574,305	632,121	57,816	9.1%	Professional Claims	1,686,202	1,916,404	230,202	12.0%
107,138	242,082	134,944	55.7%	Patient Transportation	342,684	731,561	388,877	53.2%
336,642	262,948	(73,694)	(28.0%)	Prescription Drugs	869,705	796,306	(73,399)	(9.2%)
(9,962)	59,646	69,608	116.7%	MLTSS	(9,873)	177,399	187,272	105.6%
4,750	17,805	13,055	73.3%	Other Expenses	14,288	54,062	39,775	73.6%
2,572,939	**2,937,020**	**364,081**	**12.4%**	**Total Medical Expenses**	**7,572,048**	**8,840,625**	**1,268,577**	**14.3%**
622,666	**387,231**	**235,435**	**60.8%**	**Gross Margin**	**1,973,260**	**1,037,637**	**935,623**	**90.2%**
				Administrative Expenses				
136,741	129,079	(7,662)	(5.9%)	Salaries, wages & employee benefits	411,123	360,259	(50,864)	(14.1%)
247	166	(81)	(48.6%)	Professional fees	410	498	88	17.7%
5,123	17,776	12,653	71.2%	Purchased services	8,165	53,328	45,163	84.7%
50,556	11,700	(38,856)	(332.1%)	Printing and postage	55,129	35,100	(20,029)	(57.1%)
2,018	2,070	52	2.5%	Depreciation & amortization	6,125	6,210	85	1.4%
3,317	3,537	220	6.2%	Other operating expenses	8,838	10,671	1,833	17.2%
1,294	4,445	3,151	70.9%	Indirect Cost Allocation, Occupancy Expense	9,513	13,260	3,747	28.3%
199,295	**168,773**	**(30,522)**	**(18.1%)**	**Total Administrative Expenses**	**499,303**	**479,326**	**(19,977)**	**(4.2%)**
				Operating Tax				
5,639	-	5,639	0.0%	Tax Revenue	16,962	-	16,962	0.0%
5,639	-	(5,639)	0.0%	Premium Tax Expense	16,962	-	(16,962)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
423,371	**218,458**	**204,913**	**93.8%**	**Change in Net Assets**	**1,473,958**	**558,311**	**915,647**	**164.0%**
80.5%	***88.4%***	***7.8%***	***8.9%***	***Medical Loss Ratio***	***79.3%***	***89.5%***	***10.2%***	***11.4%***
6.2%	***5.1%***	***(1.2%)***	***(22.8%)***	***Admin Loss Ratio***	***5.2%***	***4.9%***	***(0.4%)***	***(7.8%)***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2020

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				
51,107	55,000	3,893	7.1%	Purchase services	139,880	165,000	25,120	15.2%
170,912	177,250	6,338	3.6%	Depreciation & amortization	512,735	531,750	19,015	3.6%
18,423	18,500	77	0.4%	Insurance expense	55,268	55,500	232	0.4%
102,600	114,916	12,316	10.7%	Repair and maintenance	300,554	344,750	44,196	12.8%
74,108	41,250	(32,858)	(79.7%)	Other Operating Expense	202,519	123,750	(78,769)	(63.7%)
(417,149)	(406,916)	10,233	2.5%	Indirect allocation, Occupancy	(1,210,957)	(1,220,750)	(9,793)	(0.8%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – SEPTEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.2 million, favorable to budget $0.1 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $0.2 million

CalOptima
Balance Sheet
September 30, 2020

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
	Operating Cash	$284,740,279		Accounts Payable	$78,560,784
	Investments	891,165,559		Medical Claims liability	905,686,994
	Capitation receivable	326,098,561		Accrued Payroll Liabilities	16,648,281
	Receivables - Other	49,066,605		Deferred Revenue	21,883,519
	Prepaid expenses	6,185,523		Deferred Lease Obligations	152,624
				Capitation and Withholds	151,785,687
	Total Current Assets	**1,557,256,527**		**Total Current Liabilities**	**1,174,717,888**
Capital Assets					
	Furniture & Equipment	39,890,502			
	Building/Leasehold Improvements	10,852,654			
	505 City Parkway West	51,620,226			
		102,363,381			
	Less: accumulated depreciation	(54,836,309)			
	Capital assets, net	47,527,072	Other (than pensions) post		
				employment benefits liability	25,938,821
Other Assets			Net Pension Liabilities		27,321,866
	Restricted Deposit & Other	300,000	Bldg 505 Development Rights		-
	Homeless Health Reserve	57,198,913			
	Board-designated assets:			**TOTAL LIABILITIES**	**1,227,978,574**
	Cash and Cash Equivalents	3,479,829			
	Long-term Investments	583,746,489	Deferred Inflows		
	Total Board-designated Assets	587,226,318		Excess Earnings	506,547
				OPEB 75 Difference in Experience	804,000
				Change in Assumptions	3,728,725
	Total Other Assets	644,725,231		OPEB Changes in Assumptions	1,638,000
			Net Position		
TOTAL ASSETS		**2,249,508,830**		TNE	102,433,561
				Funds in Excess of TNE	924,080,492
Deferred Outflows			**TOTAL NET POSITION**		1,026,514,054
	Contributions	1,047,297			
	Difference in Experience	4,280,308			
	Excess Earning	-			
	Changes in Assumptions	5,060,465			
	OPEB 75 Changes in Assumptions	703,000			
	Pension Contributions	570,000			
	TOTAL ASSETS & DEFERRED OUTFLOWS	**2,261,169,900**		**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,261,169,900**

CalOptima
Board Designated Reserve and TNE Analysis
as of September, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,665,965				
	Tier 1 - MetLife	159,458,405				
	Tier 1 - Wells Capital	159,798,287				
Board-designated Reserve		479,922,656	319,097,426	499,753,563	160,825,231	(19,830,907)
TNE Requirement	Tier 2 - MetLife	107,303,662	102,433,561	102,433,561	4,870,100	4,870,100
	Consolidated:	**587,226,318**	**421,530,987**	**602,187,124**	**165,695,331**	**(14,960,806)**
	Current reserve level	*1.95*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
September 30, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	6,539,064	1,382,757
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	462,966	1,395,416
Changes in assets and liabilities:		
Prepaid expenses and other	742,026	513,686
Catastrophic reserves		
Capitation receivable	19,298,660	71,204,859
Medical claims liability	11,875,794	(11,465,026)
Deferred revenue	(455,272)	(1,540,177)
Payable to health networks	9,758,608	8,804,659
Accounts payable	(19,871,793)	3,904,338
Accrued payroll	1,414,765	3,340,217
Other accrued liabilities	(8,234)	(8,234)
Net cash provided by/(used in) operating activities	29,756,584	77,532,493
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(106,052,711)	(301,699,457)
Change in Property and Equipment	(726,258)	(2,267,918)
Change in Board designated reserves	(211,379)	(2,342,425)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(106,990,348)	(306,309,799)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(77,233,764)	(228,777,306)
CASH AND CASH EQUIVALENTS, beginning of period	$361,974,043	513,517,584
CASH AND CASH EQUIVALENTS, end of period	**284,740,279**	**284,740,279**

BALANCE SHEET – SEPTEMBER MONTH:

ASSETS of $2.3 billion increased $9.3 million from August or 0.4%

- Operating Cash decreased $77.2 million due to the timing of cash receipts and disbursements
- Investments increased $106.1 million due to the timing of cash receipts and month-end requirements for operating cash
- Capitation Receivables decreased $21.6 million due to timing of cash receipts

LIABILITIES of $1.2 billion increased $2.7 million from August or 0.2%

- Claims Liabilities increased $11.9 million due to timing of claim payment and changes in Incurred But Not Reported (IBNR)
- Capitation and Withholds increased $9.8 million due to timing of capitation payments
- Accounts Payable decreased $20.0 million due to payment of Managed Care Organization (MCO) tax

NET ASSETS of $1.0 billion, increased $6.5 million from August or 0.6%

Homeless Health Initiative and Allocated Funds
as of September 30, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Be Well OC	$11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Day & QI Program	1,231,087	
FQHC Mobile Unit Claims	300,000	
FQHC Mobile Unit Staff	270,000	
Home Clinic Access Program (HCAP) Expansion - Telehealth and Clinical Field Team (CFT) On Call Days	1,000,000	
Funds Allocation Total		42,801,087
Program Commitment Balance, available for new initiatives:		$57,198,913

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.
This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for September 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021

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 Finance and Audit Committee Meeting
November 19, 2020

Information Systems Security Update - Quarter Ending September 30, 2020

Recent and Upcoming Activities:

Security Events:

- There was no downtime caused by any security incidents in the quarter, and there were no incidents that were reported in the public media.

- The Information Security team reported 21 Data Loss Prevention incidents to the Privacy team. Some of these were related to accidental emails sent by users to their personal email accounts (10) and others were related to accidental copy of PHI on Google search field.

Preventive Activities:

- CalOptima takes proactive actions to prevent security incidents that could lead to breaches of electronic data, including member protected health information. One of those actions is conducting regular employee "phishing" tests to train employees on the risks of opening fraudulent e-mails seeking to gain access to CalOptima data. Phishing is a cybercrime in which a target or targets are contacted by e-mail, telephone, or text message by someone posing as a trusted source. The cybercriminal lures individuals through one or more sham e-mails in order to gain access to systems and obtain sensitive data such as personally identifiable information, banking and credit card details, and passwords, often resulting in exportation of protected health information (PHI), identity theft, and financial loss.

- The Information Security team completed the second bi-annual enterprise phishing test in July 2020, with a failure rate of 0.57%, which was a marked improvement and lower than the previous test (at 3.97%). In addition, the team also completed the 4th Quarter new employee test in October with a failure rate of 4.8%, which was well below the national average (of 14.1%) from users who received some security trainings and were tested during their first 90 days.

- Information Security is conducting our annual Cyber Security awareness month activities in October. This yearly event's focus is on raising user awareness towards Cyber risks and helping everyone improve the security of their data.

Analysis:

The failure rate of the latest quarterly (Q4) new employee test in 2020 was 4.8% (4 users failed) and it was well below the national average (14.1%). This shows that our security awareness trainings (e.g. the New Employee Orientation security training, the online security training class, monthly security e-Newsletters and e-News) are effective.

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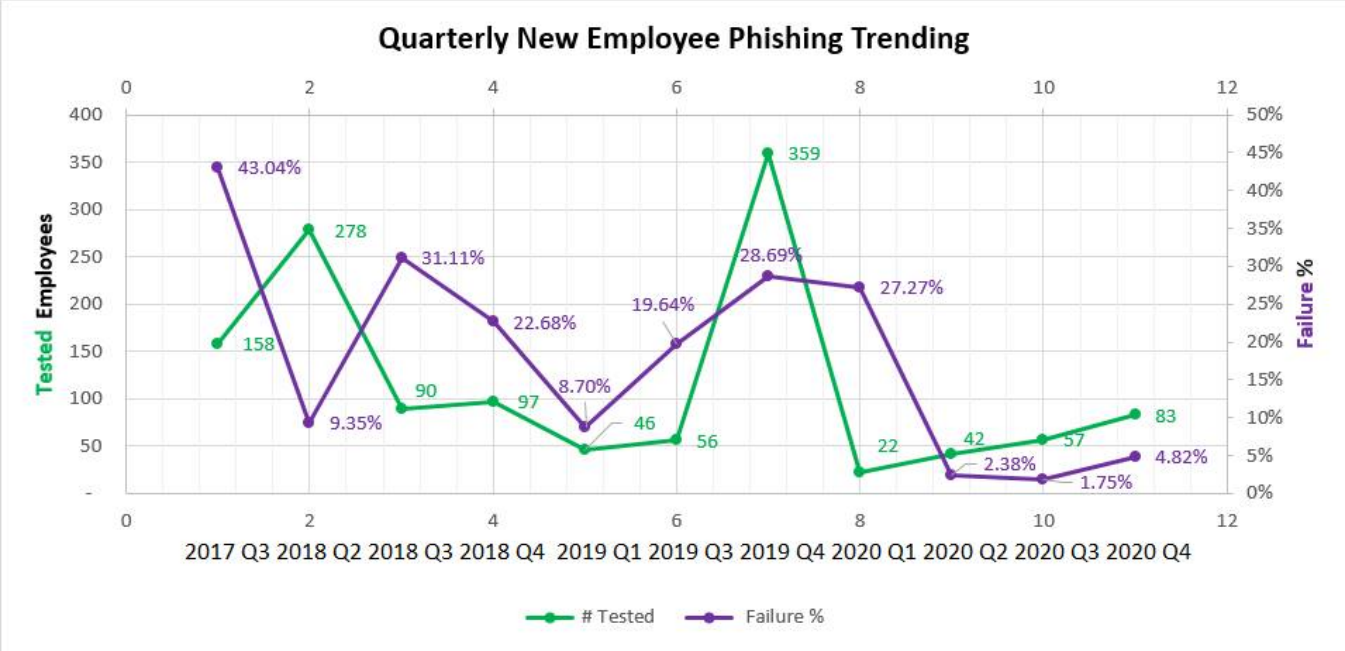
Note: Average failure rate observed by Knowbe4:

From users who received no security training and were phishing-tested the first time = 38%

From users who received security trainings and were tested during their first 90 days = 14.1%

From users who received regular security trainings and were tested monthly = 4.7%



The following table illustrates the total inbound email traffic that passes through our IronPort appliance, categorized by threat type. Our goal is to ensure the delivery of clean messages to the intended CalOptima email recipients, while reducing our threat surfaces from malicious or unwelcome senders.

Analysis:

CalOptima received nearly **4.1M** email messages in the third quarter. Of these, **3.5M** were considered as dangerous and blocked at one of our layers of security (most of these messages were from senders of poor reputation (i.e. based on complaint rates, message volume statistics, and data from public blacklists and open proxy lists), many are also from spammers). The remaining (**~550K**) were considered clean or not malicious (passing through our security filters).

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Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by Reputation Filtering	74.9%	3.0M
Stopped as Invalid Recipients	0.0%	282
Spam Detected	3.3%	133.3k
Virus Detected	0.0%	29
Detected by Advanced Malware Protection	0.0%	24
Messages with Malicious URLs	0.0%	507
Stopped by Content Filter	0.9%	34.5k
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**79.0%**	**3.2M**
Marketing Messages	3.8%	152.2k
Social Networking Messages	0.1%	5,735
Bulk Messages	3.6%	144.1k
Total Graymails:	**7.4%**	**302.0k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	13.6%	549.9k
Total Attempted Messages:		**4.1M**

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Quarterly Operating and Capital Budget Update

July 1, 2020 to September 30, 2020

Board of Directors' Finance and Audit Committee Meeting
November 19, 2020

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Quarterly Operating Budget Update as of September 30, 2020

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FY 2020-21 Board Approved Attachment A

Attachment A

CalOptima Fiscal Year 2020-21 Budget
By Line of Business

	Medi-Cal	OCC	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	9,414,022	167,856	16,536	5,211	2,730	-	**9,603,625**
Avg Members	784,502	13,988	1,378	434	455	-	**800,302**
Revenues							
Capitation revenue	$ 3,185,809,324	$ 306,323,384	$ 19,472,782	$ 42,189,583	$ 1,218,536	$ -	**$ 3,555,013,609**
Total	$ 3,185,809,324	$ 306,323,384	$ 19,472,782	$ 42,189,583	$ 1,218,536	$ -	**$ 3,555,013,609**
Medical Costs							
Provider capitation	$ 1,170,861,804	$ 132,514,946	$ 5,220,667	$ -	$ -	$ -	**$ 1,308,597,418**
Claims Payments	$ 1,078,052,514	$ 59,102,790	$ 6,184,669	$ 18,272,209	$ -	$ -	**$ 1,161,612,182**
LTC/Skilled Nursing Facilities	$ 483,084,055	$ 18,145,318	$ -	$ 826,406	$ 158,410	$ -	**$ 502,214,188**
Prescription Drugs	$ 280,984,871	$ 70,776,758	$ 5,897,339	$ 3,427,259	$ -	$ -	**$ 361,086,227**
Case Mgmt & Oth Medical	$ 91,753,453	$ 17,022,816	$ 525,047	$ 15,205,649	$ 636,667	$ -	**$ 125,143,633**
Total	$ 3,104,736,697	$ 297,562,629	$ 17,827,723	$ 37,731,523	$ 795,076	$ -	**$ 3,458,653,648**
MLR	***97.5%***	***97.1%***	***91.6%***	***89.4%***	***65.2%***		***97.3%***
Gross Margin	$ 81,072,627	$ 8,760,755	$ 1,645,059	$ 4,458,061	$ 423,459	$ -	**$ 96,359,961**
Administrative Expenses							
Salaries, Wages, & Employee Benefits	$ 83,409,902	$ 9,604,947	$ 812,160	$ 1,524,159	$ 346,127	$ -	**$ 95,697,295**
Professional Fees	$ 3,752,802	$ 481,000	$ 192,000	$ 2,000	$ 4,298	$ -	**$ 4,432,100**
Purchased services	$ 12,467,137	$ 1,240,950	$ 117,000	$ 213,324	$ 248	$ 660,000	**$ 14,698,659**
Printing & Postage	$ 5,320,902	$ 1,278,220	$ 97,000	$ 140,400	$ 248	$ 2,000	**$ 6,838,770**
Depreciation & Amortization	$ 5,502,000	$ -	$ -	$ 24,840	$ -	$ 2,127,000	**$ 7,653,840**
Other Operating Expenses	$ 20,029,432	$ 194,275	$ 6,450	$ 42,670	$ 47,890	$ 2,094,000	**$ 22,414,717**
Indirect Cost Allocation, Occupancy Expense	$ (2,576,689)	$ 6,641,906	$ 422,224	$ 55,254	$ 31,198	$ (4,883,000)	**$ (309,107)**
Total	$ 127,905,486	$ 19,441,298	$ 1,646,834	$ 2,002,647	$ 430,009	$ -	**$ 151,426,274**
ALR	***4.0%***	***6.3%***	***8.5%***	***4.7%***	***35.3%***		***4.3%***
Operating Income/(Loss)	$ (46,832,859)	$ (10,680,544)	$ (1,774)	$ 2,455,414	$ (6,550)	$ -	**$ (55,066,313)**
Investment Income							$ 15,000,000
MCO Tax Revenue	$ 182,255,794						$ 182,255,794
MCO Tax Expense	$ (182,255,794)						$ (182,255,794)
CHANGE IN NET ASSETS	**$ (46,832,859)**	**$ (10,680,544)**	**$ (1,774)**	**$ 2,455,414**	**$ (6,550)**	**$ -**	**$ (40,066,313)**

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Board Action Approval Details and Summary for Administrative Budget

CalOptima Fiscal Year 2020-21 Budget
Board Action Approval Summary

Board Action Approval Summary	Medi-Cal	OCC	OneCare	PACE	MSSP	Facilities	Net Impact
Medical Costs	$ -	$ -	$ -	$ 132,000	$ -	$ -	$ 132,000
Administrative Expenses							
Salaries, Wages, & Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Fees	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchased services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Printing & Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Depreciation & Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Operating Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Indirect Cost Allocation, Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Net Impact	**$ -**	**$ -**	**$ -**	**$ 132,000**	**$ -**	**$ -**	**$ 132,000**

CalOptima Fiscal Year 2020-21 Budget
Board Action Approval Details

Board Action Approval Details:	Medi-Cal	OCC	OneCare	PACE	MSSP	Facilities	Net Impact
1 BOD Date - September 3, 2020 Report Item No. 4 To: Medical Costs				$ 132,000.00			**$ 132,000**

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CEO Administrative Budget Allocation Changes

Administrative Budget Allocation Changes
Reporting Changes as of September 30, 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	Repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses.	2021

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

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FY 2020-21 Revised Attachment A

CalOptima Fiscal Year 2020-21 Budget
Budgeted Statement of Revenue & Expenses
By Line of Business

Attachment A - Revised

	Medi-Cal	OCC	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	9,414,022	167,856	16,536	5,211	2,730	-	**9,603,625**
Avg Members	784,502	13,988	1,378	434	455	-	**800,302**
Revenues							
Capitation revenue	$ 3,185,809,324	$ 306,323,384	$ 19,472,782	$ 42,189,583	$ 1,218,536	$ -	**3,555,013,609**
Total	$ 3,185,809,324	$ 306,323,384	$ 19,472,782	$ 42,189,583	$ 1,218,536	$ -	**$ 3,555,013,609**
Medical Costs							
Provider capitation	$ 1,170,861,804	$ 132,514,946	$ 5,220,667	$ -	$ -	$ -	**$ 1,308,597,418**
Claims Payments	$ 1,078,052,514	$ 59,102,790	$ 6,184,669	$ 18,272,209	$ -	$ -	**$ 1,161,612,182**
LTC/Skilled Nursing Facilities	$ 483,084,055	$ 18,145,318	$ -	$ 826,406	$ 158,410	$ -	**$ 502,214,188**
Prescription Drugs	$ 280,984,871	$ 70,776,758	$ 5,897,339	$ 3,427,259	$ -	$ -	**$ 361,086,227**
Case Mgmt & Oth Medical	$ 91,753,453	$ 17,022,816	$ 525,047	$ 15,337,649	$ 636,667	$ -	**$ 125,275,633**
Total	$ 3,104,736,697	$ 297,562,629	$ 17,827,723	$ 37,863,523	$ 795,076	$ -	**$ 3,458,785,648**
MLR	***97.5%***	***97.1%***	***91.6%***	***89.7%***	***65.2%***		***97.3%***
Gross Margin	$ 81,072,627	$ 8,760,755	$ 1,645,059	$ 4,326,061	$ 423,459	$ -	**$ 96,227,961**
Administrative Expenses							
Salaries, Wages, & Employee Benefits	$ 83,409,902	$ 9,604,947	$ 812,160	$ 1,524,159	$ 346,127	$ -	**$ 95,697,295**
Professional Fees	$ 3,752,802	$ 481,000	$ 192,000	$ 2,000	$ 4,298	$ -	**$ 4,432,100**
Purchased services	$ 12,467,137	$ 1,240,950	$ 117,000	$ 213,324	$ 248	$ 660,000	**$ 14,698,659**
Printing & Postage	$ 5,320,902	$ 1,278,220	$ 97,000	$ 140,400	$ 248	$ 2,000	**$ 6,838,770**
Depreciation & Amortization	$ 5,502,000	$ -	$ -	$ 24,840	$ -	$ 2,127,000	**$ 7,653,840**
Other Operating Expenses	$ 20,029,432	$ 194,275	$ 6,450	$ 42,670	$ 47,890	$ 2,094,000	**$ 22,414,717**
Indirect Cost Allocation, Occupancy Expense	$ (2,576,689)	$ 6,641,906	$ 422,224	$ 55,254	$ 31,198	$ (4,883,000)	**$ (309,107)**
Total	$ 127,905,486	$ 19,441,298	$ 1,646,834	$ 2,002,647	$ 430,009	$ -	**$ 151,426,274**
ALR	***4.0%***	***6.3%***	***8.5%***	***4.7%***	***35.3%***		***4.3%***
Operating Income/(Loss)	$ (46,832,859)	$ (10,680,544)	$ (1,774)	$ 2,323,414	$ (6,550)	$ -	**$ (55,198,313)**
Investment Income							$ 15,000,000
MCO Tax Revenue	$ 182,255,794						$ 182,255,794
MCO Tax Expense	$ (182,255,794)						$ (182,255,794)
CHANGE IN NET ASSETS	**$ (46,832,859)**	**$ (10,680,544)**	**$ (1,774)**	**$ 2,323,414**	**$ (6,550)**	**$ -**	**$ (40,198,313)**

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Personnel Budget Summary

FY 2020 - 21 Personnel Summary

	FY 2020 - 21 Personnel (FTEs) - September 2020			
Line of Business	**Filled**	**Open**	**Total**	**Vacancy %**
Medi-Cal	1,056.8	88.0	1,144.8	7.7%
OC	9.3		9.3	0.0%
OCC	196.8	12.0	208.8	5.7%
PACE	93.5	22.8	116.3	19.6%
MSSP	18.0		18.0	0.0%
Total	**1,374.4**	**122.8**	**1,497.1**	**8.2%**

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

Salary Market Adjustments as of September 30, 2020

Title	Effective Date	Quarter	Market Adjustment (% Increase)
Controller	7/5/2020	Q1	11.772%
Supervisor Finance	9/27/2020	Q1	17.381%
Director Customer Service	8/2/2020	Q1	9.360%
		Total Financial Impact	$44,104.91

Post-Budget Re-Evaluations as of September 30, 2020

Title	Effective Date	Quarter	Market Adjustment (% Increase)
Sr Manager Human Resources	09/27/2020	Q1	12.089%
		Total Financial Impact	$14,310.08

Source: Salary Market Adjustments and Post-Budget Re-Evaluations provided by the Human Resources Department

Administrative Expense Summary by Category

Administrative Expense Summary by Category as of September 30, 2020

Consolidated Administrative Expense Summary

LOB	September MTD Actual	September MTD Budget	Variance $	Variance %	YTD Actual	YTD Budget	Variance $	Variance %	FY 2021 Budget
MC	$ 2,775,515	$ 3,575,894	$ 800,379	22%	$ 7,706,208	$ 10,730,235	$ 3,024,027	28%	$ 41,622,956
OC	$ 41,067	$ 34,371	$ (6,696)	-19%	$ 94,086	$ 103,113	$ 9,027	9%	$ 412,450
OCC	$ 188,694	$ 265,873	$ 77,179	29%	$ 576,167	$ 798,613	$ 222,446	28%	$ 3,194,445
PACE	$ 59,243	$ 33,179	$ (26,064)	-79%	$ 72,541	$ 99,597	$ 27,056	27%	$ 398,394
Total	**$ 3,064,518**	**$ 3,909,317**	**$ 844,799**	**22%**	**$ 8,449,002**	**$ 11,731,558**	**$ 3,282,556**	**28%**	**$ 45,628,245**

Professional Fees

LOB	September MTD Actual	September MTD Budget	Variance $	Variance %	YTD Actual	YTD Budget	Variance $	Variance %	FY 2021 Budget
MC	$ 308,388	$ 313,093	$ 4,705	2%	$ 789,306	$ 939,279	$ 149,973	16%	$ 3,757,100
OC	$ 16,000	$ 16,000	$ -	0%	$ 48,000	$ 48,000	$ -	0%	$ 192,000
OCC	$ 5,333	$ 40,083	$ 34,750	87%	$ 16,000	$ 120,249	$ 104,249	87%	$ 481,000
PACE	$ 247	$ 166	$ (81)	-49%	$ 410	$ 498	$ 88	18%	$ 2,000
Total	**$ 329,968**	**$ 369,342**	**$ 39,374**	**11%**	**$ 853,716**	**$ 1,108,026**	**$ 254,310**	**23%**	**$ 4,432,100**

Purchased Services

LOB	September MTD Actual	September MTD Budget	Variance $	Variance %	YTD Actual	YTD Budget	Variance $	Variance %	FY 2021 Budget
MC	$ 759,832	$ 1,146,263	$ 386,431	34%	$ 2,048,002	$ 3,438,790	$ 1,390,788	40%	$ 12,467,385
OC	$ 7,945	$ 9,750	$ 1,805	19%	$ 17,332	$ 29,250	$ 11,918	41%	$ 117,000
OCC	$ 91,512	$ 103,412	$ 11,900	12%	$ 258,417	$ 310,236	$ 51,819	17%	$ 1,240,950
PACE	$ 5,123	$ 17,776	$ 12,653	71%	$ 8,165	$ 53,328	$ 45,163	85%	$ 213,324
Total	**$ 864,411**	**$ 1,277,201**	**$ 412,790**	**32%**	**$ 2,331,915**	**$ 3,831,604**	**$ 1,499,689**	**39%**	**$ 14,038,659**

Printing and Postage

LOB	September MTD Actual	September MTD Budget	Variance $	Variance %	YTD Actual	YTD Budget	Variance $	Variance %	FY 2021 Budget
MC	$ 124,779	$ 443,433	$ 318,654	72%	$ 587,623	$ 1,330,299	$ 742,676	56%	$ 5,321,150
OC	$ 17,122	$ 8,084	$ (9,038)	-112%	$ 28,549	$ 24,252	$ (4,297)	-18%	$ 97,000
OCC	$ 55,587	$ 106,517	$ 50,930	48%	$ 186,917	$ 319,551	$ 132,634	42%	$ 1,278,220
PACE	$ 50,556	$ 11,700	$ (38,856)	-332%	$ 55,129	$ 35,100	$ (20,029)	-57%	$ 140,400
Total	**$ 248,044**	**$ 569,734**	**$ 321,690**	**56%**	**$ 858,217**	**$ 1,709,202**	**$ 850,985**	**50%**	**$ 6,836,770**

Other Operating Expenses

LOB	September MTD Actual	September MTD Budget	Variance $	Variance %	YTD Actual	YTD Budget	Variance $	Variance %	FY 2021 Budget
MC	$ 1,582,517	$ 1,673,105	$ 90,588	5%	$ 4,281,277	$ 5,021,867	$ 740,590	15%	$ 20,077,321
OC	$ -	$ 537	$ 537	100%	$ 205	$ 1,611	$ 1,406	87%	$ 6,450
OCC	$ 36,262	$ 15,861	$ (20,401)	-129%	$ 114,834	$ 48,577	$ (66,257)	-136%	$ 194,275
PACE	$ 3,317	$ 3,537	$ 220	6%	$ 8,838	$ 10,671	$ 1,833	17%	$ 42,670
Total	**$ 1,622,095**	**$ 1,693,040**	**$ 70,945**	**4%**	**$ 4,405,154**	**$ 5,082,726**	**$ 677,572**	**13%**	**$ 20,320,716**

Administrative expense summary by category does not include expenditures and budget for Facilities.

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Quarterly Capital Budget Update as of September 30, 2020

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FY 2020-21 Capital Attachment A

Attachment A

Fiscal Year 2020-21 Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Network - Firewall Upgrade	450,000			450,000
Network - Wireless System Upgrade	430,000			430,000
Security - IT Asset Management Solution	100,000	150,000	50,000	300,000
Security - Identity and Access Management	70,000		200,000	270,000
Server - Server Blade Replacement	200,000			200,000
Network - Business Partner VPN Upgrade	160,000			160,000
Network - Wide Area Network Firewall	150,000			150,000
Network - RSA Security Upgrade	93,000			93,000
Server - Array Replacement	54,000			54,000
Telephony - Upgrade Contact Center	25,000	25,000		50,000
Network - PACE Router	19,000			19,000
Server - Additional Storage Area Network Switch Ports	13,000			13,000
Server - Upgrade Switches in VM Blade Enclosures	9,000			9,000
TOTAL INFRASTRUCTURE	**$ 1,773,000**	**$ 175,000**	**$ 250,000**	**$ 2,198,000**

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Interoperability (Final Rule FHIR)	250,000	1,750,000	500,000	2,500,000
Medical Management System	250,000	1,500,000	500,000	2,250,000
Core System Supplemental Management	125,000	1,150,000	500,000	1,775,000
Pricer Integration Software		1,000,000	200,000	1,200,000
Provider Data Management Solution	250,000	750,000	125,000	1,125,000
Burgess Reimbursement System Upgrade		450,000	100,000	550,000
Predictive Analytics		400,000	100,000	500,000
Hardware for Robots	200,000			200,000
Cactus Integration to Facets	70,000		100,000	170,000
Additional Memory, CPU and Disc Space	50,000			50,000
Storage Server Equipment	50,000			50,000
TOTAL APPLICATIONS MANAGEMENT	**$ 1,245,000**	**$ 7,000,000**	**$ 2,125,000**	**$ 10,370,000**

APPLICATIONS DEVELOPMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Provider Portal File Server/Build Matching Infrastructure	550,000	35,000	60,000	645,000
Sitecore Upgrade	125,000	100,000	200,000	425,000
Litigation Hold and Discovery on Applications		350,000		350,000
Enterprise Content Management System Consultation and Build			200,000	200,000
Data Governance and Meta Data Management Increase	60,000	50,000	24,000	134,000
Portal Hardware to Support Reporting	60,000			60,000
Data Warehouse Analysis by Business	60,000			60,000
Team Foundation Server Upgrade	10,000	9,000	20,000	39,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 865,000**	**$ 544,000**	**$ 504,000**	**$ 1,913,000**

505 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
Office Renovations	380,000		35,000	415,000
Multiple Bathroom Upgrades	300,000		75,000	375,000
Lobby Security Improvements	250,000		50,000	300,000
1st Floor Conference Rooms	110,000		25,000	135,000
Cooling Tower Continuation	80,000			80,000
Copier Replacements and Lease	75,000			75,000
Install Sink Heating for Restrooms Floors 5-10	50,000			50,000
Conference Rooms Upgrades	37,000		5,000	42,000
Replace Ground Floor Corridor Heating and Cooling Boxes	35,000			35,000
IDF Room HVAC Continuation	20,000		5,000	25,000
Replace Ceiling in Passenger Elevators	25,000			25,000
Upgrade Building Security Cameras	22,000			22,000
1st Floor Card Reader Addition	20,000			20,000
Replace Trash Room Double Doors with Fire Rated Doors	15,000			15,000
Replace Domestic Water Circulation Pump	12,000			12,000
Recording Studio	10,000			10,000
TOTAL 505 BUILDING IMPROVEMENTS	**$ 1,441,000**	**$ -**	**$ 195,000**	**$ 1,636,000**

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FY 2020-21 Capital Attachment A (Cont'd)

PACE	EQUIPMENT		PROFESSIONAL FEES	TOTAL CAPITAL
Workspace Efficiency and Expansion	57,000	-	-	$57,000
Rehab Equipment	15,000	-	-	$15,000
Audiovisual and Conference Room	12,000	-	-	$12,000
Lobby Refurbishment	10,000	-	-	$10,000
Clinic Doors Handicap Access	7,000	-	-	$7,000
Internal Staff Communication	6,000	-	-	$6,000
Clinic Spirometer	5,000	-	-	$5,000
Commercial Freezer	5,000	-	-	$5,000
Exterior Electricity	2,000	-	-	$2,000
TOTAL PACE	**$ 119,000**	**$ -**	**$ -**	**$ 119,000**
TOTAL FY 2020-21 CAPITAL BUDGET	**$ 5,443,000**	**$ 7,719,000**	**$ 3,074,000**	**$ 16,236,000**

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Board Action and CEO Approval Details for Capital Projects

There were no FY21 capital project budget reallocations to report in the first quarter.

CEO Capital Budget Allocation Changes

There were no FY21 capital project budget reallocations to report in the first quarter.

FY 2020-21 Revised Capital Attachment A

There were no FY21 capital project budget reallocations to report in the first quarter.

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Quarterly Purchasing Report

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FY 2020-21 First Quarter Purchasing Report

Quarterly Purchase Report
July 1, 2020 through September 30, 2020
Completed Major Commitments over $100,000

Nature of Services	*FY21 Q1 Budgeted Current*	*Purchase or Contract Highlights*	*Bidding Outcome*	*Previous Vendor*	*Contract Amount*	*Spent Year 2021*	*Remaining Amount on Contract*	*Expires*
PACE Janitorial Services	$ 106,083	Able Building Maint Co	Renewal		$ 106,083	$ 22,600	$ 83,483	02/28/23
Storage Services	$ 110,000	Cor-O-Van Moving & Storage Co	Renewal		$ 110,000	$ 20,811	$ 89,189	10/31/21
Employee Benefit Broker	$ 115,000	Alliant Insurance Services Inc	Five bids received	Alliant	$ 115,000	$ 28,750	$ 86,250	03/31/23
Insurance Brokerage and Advisory Services	$ 115,000	Woodruff- Sawyer & Co.	Renewal		$ 115,000	$ -	$ 115,000	09/30/21
HP Support Services	$ 128,459	Nth Generation Computing Inc	Renewal		$ 128,459	$ -	$ 128,459	06/30/21
OCC Mailing and Fulfillment	$ 130,786	Kenny the Printer	Six bids received	Kenny the Printer	$ 130,786	$ 59,948	$ 70,838	06/30/21
Monitors and Soundbars	$ 133,422	Dell Computers	Renewal		$ 133,422	$ 133,422	$ -	12/31/20
Strategic Communication Services	$ 144,000	Westbound Communications Inc	Renewal		$ 144,000	$ -	$ 144,000	06/30/21
Palo Alto Network Support	$ 149,963	Integration Partners	Two bids received	New	$ 149,963	$ 149,963	$ -	06/30/21
Medication Therapy Management	$ 156,000	Star MTM LLC	Renewal		$ 156,000	$ 26,000	$ 130,000	02/28/23
Palo Alto Network Support	$ 159,821	Integration Partners	Two bids received	New	$ 159,821	$ 159,821	$ -	06/30/21
Telephone Interpreting Services	$ 177,221	Voiance Language Services, LLC	Renewal		$ 177,221	$ 69,760	$ 107,461	06/30/21
PACE Medical Management System	$ 195,000	Tabula Rasa Healthcare	Renewal		$ 195,000	$ 32,138	$ 162,863	02/27/21
Data Center Lease	$ 198,000	Orange County Treasurer-Tax Collector	Renewal		$ 198,000	$ 23,428	$ 174,572	06/30/21
MLR Auditing Services	$ 214,100	Provencio Advisory Services Inc	Renewal		$ 214,100	$ -	$ 214,100	03/31/21
Interpreting Services	$ 235,700	Language Line Services, Inc.	16 bids received. Five contracts awarded.	Language Line	$ 235,700	$ -	$ 235,700	09/30/21
Executive Search Services	$ 250,000	Witt/Kieffer Inc	Four bids received	New	$ 250,000	$ -	$ 250,000	06/30/21
HP Software and Server Support Services	$ 253,106	Nth Generation Computing Inc	Bid exception	Nth Generation	$ 253,106	$ -	$ 253,106	06/30/21
Member Communications Mailing	$ 269,287	Dome Printing	Renewal		$ 269,287	$ 82,020	$ 187,267	06/30/21

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FY 2020-21 First Quarter Purchasing Report (Cont'd)

Nature of Services	*FY21 Q1 Budgeted Current*	*Purchase or Contract Highlights*	*Bidding Outcome*	*Previous Vendor*	*Contract Amount*	*Spent Year 2021*	*Remaining Amount on Contract*	*Expires*
IT Research Services	$ 298,051	Gartner Inc	Renewal		$ 298,051	$ 298,051	$ 0	6/31/21
Provider Exclusion Monitoring	$ 311,520	LexisNexis	Renewal		$ 311,520	$ 5,681	$ 305,839	07/30/21
Interpreting Services	$ 335,000	Interpreting Services International, LLC	Renewal		$ 335,000	$ -	$ 335,000	02/28/23
Document Imaging Services	$ 351,000	Imagenet LLC	Renewal		$ 351,000	$ 18,066	$ 332,934	06/30/21
Palo Alto Network Support	$ 448,835	Integration Partners	Two bids received	New	$ 448,835	$ 449,294	$ (459)	06/30/21
CAHPS Surveys	$ 478,578	DataStat	Renewal		$ 478,578	$ 229,503	$ 249,074	04/30/21
Member Communications Mailing	$ 503,758	The Dot Printer Inc	Renewal		$ 503,758	$ 5,022	$ 498,736	04/30/23
OTC Supplemental Benefit	$ 554,089	Convey Health Solutions Inc	Renewal		$ 554,089	$ 83,882	$ 470,208	12/31/21
TANF to SSI Conversion Services	$ 620,000	Human Arc Corporation of Ohio	Three bids received	Human Arc	$ 620,000	$ 81,200	$ 538,800	06/30/23
PACE Shuttle Services	$ 900,000	Secure Transportation Company Inc	Renewal		$ 900,000	$ 321,668	$ 578,332	06/30/21
Cooling Tower Replacement	$ 916,690	Mesa Energy Systems Inc.	One bid received	EMCOR/Mesa Energy	$ 916,690	$ 678,234	$ 238,457	Complete
Mobile Texting Services	$ 962,615	mPulse Mobile, Inc.	Eight bids received	New	$ 962,615	$ 160,586	$ 802,029	07/31/23
Claims Clearinghouse Services	$ 1,020,000	Office Ally, LLC	Renewal		$ 1,020,000	$ 60,964	$ 959,037	12/31/23
Professional Claims Services	$ 1,560,000	Varis LLC	Renewal		$ 1,560,000	$ -	$ 1,560,000	09/25/21
Provider Portal Services	$ 1,584,000	Medecision Inc	Renewal		$ 1,584,000	$ 530,417	$ 1,053,583	12/31/21
Interpreting Services	$ 1,887,760	Hanna Interpreting Services LLC	Renewal		$ 1,887,760	$ 90,290	$ 1,797,470	02/28/23
Claims Editing Services	$ 1,920,000	Cotiviti Inc	Renewal		$ 1,920,000	$ 238,287	$ 1,681,713	10/07/21

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FY 2020-21 First Quarter Purchasing Report (Cont'd)

Quarterly Purchasing Report
July 1, 2020 through September 30, 2020
Major Commitments Greater than $100,000 in Process

Nature of Services	*Procurement Status*
Third Party Liability and Subrogation Services 19-030	RFP issued 4/18/2019 Three proposals received Staff is negotiating contract
Hospital Data Exchange Services 20-002	RFP issued 7/17/2019 Nine proposals received Staff is negotiating contract(s)
Learning Management Content Services 20-007	RFP issued 10/8/2019 Five proposals received Staff is negotiating contract
Interpreting Services 20-015	RFP issued 9/19/2019 Fifteen proposals received Staff awarded contracts to five vendors.
Identity Management System 20-039	RFP issued 6/20/2020 Nine proposals received Staff is negotiating contract
Architectural Services 21-002	RFP issued 7/14/2020 Three proposals received Staff awarded contract to One Nine Architecture
Interoperability Solutions 21-003	RFP issued 7/15/2020 Ten proposals received Staff is negotiating contract
eConsult platform 21-005	RFP issued 9/1/2020 Four proposals received Staff is reviewing proposals
Document/back-up tape storage and retrieval services 21-006	RFP issued 8/6/2020 Four proposals received Staff is evaluating proposals
Roofing Services 505 Building 21-007	RFP issued 9/22/2020

IGT Project Report

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IGT Project Update as of September 2020

IGTs 1-7: Funds must be used to deliver enhanced services for the Medi-Cal population

#	IGT Projects	IGT	First Payment Dispersed Date	COBAR Project End Date	Budget	Spend	% Spent	Balance	Grant Disburse-ment Date
IGT 1 (Funds Received: September 2012)									
1	Case Management System (Altruista)	1	4/7/2014	12/31/2016	$2,095,380	$2,095,380	100%	$0	Non-Grant Project
2	Telemedicine [Funds Reallocated]	1	4/7/2014	12/1/2016	$30,810	$30,810	100%	$0	Non-Grant Project
3	Strategies to Reduce Readmission	1	12/28/2014	12/31/2016	$611,421	$611,421	100%	$0	Non-Grant Project
4	OneCare PCCs	1	4/16/2014	6/30/2017	$3,850,000	$3,850,000	100%	$0	Non-Grant Project
5	OneCare Connect PCCs	1	8/18/2015	6/30/2017	$3,550,000	$3,550,000	100%	$0	Non-Grant Project
6	Case Management Consulting	1	10/1/2014	12/31/2017	$866,415	$866,415	100%	$0	Non-Grant Project
7	Clinical Field Team Pilot Program [Reallocated Funds]	1	4/8/2019	N/A	$500,000	$500,000	100%	$0	4/8/2019
8	Depression Screenings	1	2/28/2018	5/31/2019	$500,000	$455,000	91%	$45,000	Pending Reallocation
9	Shape Your Life Program	1	4/28/2017	7/1/2020	$500,000	$465,389	93%	$34,611	Non-Grant Project
SUBTOTAL					$12,504,026	$12,424,415	99%	$79,611	
IGT 2 (Funds Received: June 2013)									
1	FQHC Support Phase 1 (to support FQHC attainment)	2	7/6/2015	8/1/2017	$200,000	$200,000	100%	$0	First: 07/2015; Last: 08/2016
2	FQHC Support Phase 2 (to support FQHC readiness analysis)	2	7/6/2015	12/31/2016	$202,091	$202,091	100%	$0	First: 10/2015; Last: 11/2016
3	FQHC Support Phase 3 (behavioral/dental expansion)	2	7/6/2015	6/30/2017	$875,000	$875,000	100%	$0	First: 03/2016; Last: 05/2017
4	Children's Dental Services	2	7/2/2015	7/1/2017	$400,000	$400,000	100%	$0	First: 06/2015; Last: 08/2016
5	Children's Vision Services	2	9/8/2015	8/1/2017	$500,000	$500,000	100%	$0	First: 09/2015; Last: 08/2016
6	Security Audit Remediation	2	6/28/2014	7/1/2015	$98,000	$98,000	100%	$0	Non-Grant Project
7	PACE EHR Implementation	2	5/16/2016	12/31/2016	$80,000	$80,000	100%	$0	Non-Grant Project
8	Facets Upgrade, Expansion, and Reconfiguration	2	6/18/2014	6/30/2017	$1,756,620	$1,756,620	100%	$0	Non-Grant Project
9	Continuation of COREC	2	11/3/2014	12/31/2017	$970,000	$970,000	100%	$0	Non-Grant Project
10	Recuperative Care	2	6/1/2015	12/31/2018	$500,000	$500,000	100%	$0	Non-Grant Project
11	OneCare Connect PCCs (Continued)	2	6/28/2017	12/31/2018	$2,400,000	$2,400,000	100%	$0	Non-Grant Project
12	Autism Screening	2	8/3/2016	Reallocated to IGT 5	$51,600	$51,600	100%	$0	Non-Grant Project
SUBTOTAL					$8,033,311	$8,033,311	100%	$0	
IGT 3 (Funds Received: September 2014)									
1	Personal Care Coordinators	3	5/15/2017	5/31/2018	$3,450,000	$3,450,000	100%	$0	Non-Grant Project
2	Recuperative Care (Phase 2)	3	8/16/2018	12/31/2018	$500,000	$499,750	100%	$250	Pending Reallocation
3	Data Warehouse Expansion	3	2/14/2017	12/31/2019	$750,000	$544,607	73%	$205,393	Non-Grant Project
SUBTOTAL					$4,700,000	$4,494,357	96%	$205,643	
IGT 4 (Funds Received: October 2015/March 2016)									
1	Member Health Needs Assessment	4	4/20/2017	12/31/2017	$500,000	$500,000	100%	$0	Non-Grant Project
2	Personal Care Coordinators	4	1/17/2018	5/31/2018	$3,550,000	$3,550,000	100%	$0	Non-Grant Project
3	UCI Observation Stay Payment Pilot	4	2/7/2018	12/31/2019	$750,000	$744,600	99%	$5,400	Pending Reallocation
4	Provider Portal Communications & Interconnectivity	4	5/9/2017	12/31/2019	$1,500,000	$1,456,510	97%	$43,490	Pending Reallocation
5	Member Health Homes Program	4	9/7/2017	9/30/2019	$250,000	$177,809	71%	$72,192	Pending Reallocation
SUBTOTAL					$6,550,000	$6,428,919	98%	$121,082	

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IGT Project Update as of September 2020 (Cont'd)

#	IGT Projects	IGT	First Payment Dispersed Date	COBAR Project End Date	Budget	Spend	% Spent	Balance	Grant Disburse-ment Date
IGT 5 (Funds Received: December 2016)									
1	Be Well OC Regional Wellness Hub	5	7/10/2019	N/A	$11,400,000	$11,400,000	100%	$0	12/6/2018 (COBAR)
2	Access to Adult Dental Services (Grant RFP: Korean Community Services)	5	12/5/2019	N/A	$1,000,000	$850,000	85%	$150,000	Awarded on 8/1/19
3	Access to Children's Dental Services (Grant RFP)	5	1/15/2020	N/A	$1,000,000	$844,800	84%	$155,200	Awarded on 10/3/19
4	Primary Care Services and Programs Addressing Social Determinants of Health (Grant RFP: Santa Ana Unified School District)	5	12/4/2019	N/A	$1,411,488	$466,666	33%	$944,822	Awarded on 8/1/19
SUBTOTAL					$14,811,488	$13,561,466	92%	$1,250,022	
IGT 6 & 7 (Funds Received: September 2017/May 2018)									
1	Clinical Field Team Pilot Program	7	4/8/2019	N/A	$1,100,000	$1,100,000	100%	$0	4/8/2019
2	Post-WPC Medical Respite Program	6	TBD	N/A	$250,000	$250,000	100%	$0	4/4/2019 (COBAR)
3	Whole Child Model Assistance for Implementation and Development	6	4/2/2020	N/A	$1,750,000	$1,617,110	92%	$132,890	Non-Grant Project
4	Expand Access to Food Distribution Services Focused on Children and Families (Grant RFP: Serve the People)	7	12/11/2019	9/30/2022	$1,000,000	$750,470	75%	$249,530	Awarded on 8/1/19
5	Expand Access to Outpatient Children's Mental Health Services (Grant RFP: Children's Bureau of Southern California; Orange County Asian & Pacific Islander Community Alliances, Inc,; Boys & Girls Clubs of Garden Grove; Jamboree Housing Corporation)	6	10/28/2019	6/30/2023	$4,188,990	$2,314,007	55%	$1,874,983	Awarded on 8/1/19
6	Integrate Children's Mental Health Services Into Primary Care Settings (Grant RFP: CHOC Children's; Friends of Family Health Center)	7	12/4/2019	6/30/2024	$4,850,000	$1,733,223	36%	$3,116,777	Awarded on 8/1/19
7	Increase Access to Medication-Assisted Treatment (Grant RFP: Coalition of Orange County Community Health Center)	7	12/4/2019	6/30/2023	$6,000,000	$2,000,000	33%	$4,000,000	Awarded on 8/1/19
8	WPC Recuperative Care	6	6/20/2019	N/A	$7,250,000	$2,049,610	28%	$5,200,390	8/2/2018 (COBAR)
9	Master Electronic Health Record System	6	8/7/2020	N/A	$650,000	$63,858	10%	$586,142	Non-Grant Project
10	Housing Support Services	6	TBD	N/A	$2,500,000	$0	0%	$2,500,000	12/5/2019 (COBAR)
11	Expand Access to Outpatient Children's Mental Health Services (Grant RFP: Children's Bureau of Southern California; Orange County Asian & Pacific Islander Community Alliances, Inc,; Boys & Girls Clubs of Garden Grove; Jamboree Housing Corporation)	7	TBD	6/30/2023	$661,010	$0	0%	$661,010	Awarded on 8/1/19
SUBTOTAL					$30,200,000	$11,878,278	39%	$18,321,722	
GRAND TOTAL					**$76,798,825**	**$56,820,746**	74%	**$19,978,079**	

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IGT Project Update as of September 2020 (Cont'd)

IGTs 8-9: Funds must be used for Medi-Cal covered services for the Medi-Cal population

#	IGT Projects	IGT	First Payment Dispersed Date	COBAR Project End Date	Budget	Spend	% Spent	Balance	Grant Disburse-ment Date
IGT 8 (Funds Received: March 2019/April 2019)									
1	Homeless Health Initiative								
	CalOptima Days & QI Program	8		$2,231,087	$616,754	28%	$1,614,333	8/1/2019	
	Homless Coordination at Hospitals	8		$10,000,000	$2,500,000	25%	$7,500,000	4/4/2019	
	FQHC Mobile Unit Staff	8		$270,000	$61,269	23%	$208,731	8/1/2019	
	Homeless Response Team	8		$6,000,000	$703,241	12%	$5,296,759	4/4/2019	
	FQHC Mobile Unit Claims (08/2019-03/2020)	8		$300,000	$24,972	8%	$275,028	8/1/2019	
	New initiatives	8		$23,962,104	$0	0%	$23,962,104	TBD	
SUBTOTAL				$42,763,191	$3,906,236	9%	$38,856,955		
IGT 9 (Funds Received: April 2020)									
1	Whole Child Model (WCM) Program	9		$30,030,950	$29,043,292	97%	$987,658	4/2/2020	
2	OC COVID-19 Skilled Nursing Facility Prevention Program	9		$629,723	$309,137	49%	$320,586	5/7/2020	
3	Text Messaging Solutions for Members	9		$3,900,000	$439,722	11%	$3,460,278	5/7/2020	
4	Expanded Office Hours	9		$2,000,000	$0	0%	$2,000,000	4/2/2020	
5	Post-Acute Infection Prevention (PIPQI)	9		$3,400,000	$0	0%	$3,400,000	4/2/2020	
6	Hospital Data Exchange Incentive	9		$2,000,000	$0	0%	$2,000,000	4/2/2020	
SUBTOTAL				$41,960,673	$29,792,151	71%	$12,168,522		
GRAND TOTAL				**$84,723,864**	**$33,698,387**	40%	**$51,025,477**		

Source: IGT Project Report provided by the Strategic Development Department.

Board of Directors' Finance and Audit Committee Meeting
November 19, 2020

Shared Risk Pool Performance Update

Medi-Cal: As of September 30, 2020, Medi-Cal has five (5) Shared Risk Groups (SRGs).

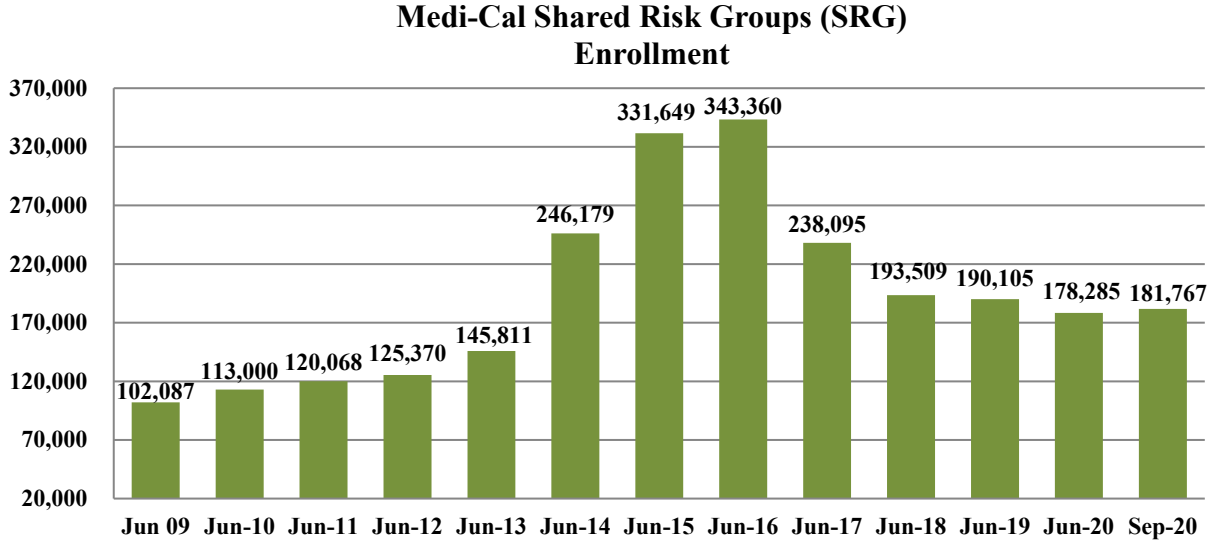
Effective Dates:

- Noble and Talbert – January 2008
- AltaMed – March 2014
- Prospect* – May 2007 to June 2017
- Arta and UCMG – July 2008
- Monarch* – July 2008 to January 2017

** Monarch became an HMO group in February 2017. Prospect became an HMO group in July 2017.*

Enrollment

SRGs are serving approximately 182,000 members. It represents about 24% of CalOptima's Medi-Cal enrollment.



Pool Performance - (Medi-Cal Classic + Expansion)

Fiscal Year	Gross Deficit	Gross Surplus	CalOptima Share (40%)	Group Share (60%)	Number of SRGs Total	In Deficit	In Surplus
2007	$ (729,095)	$ -	$ (573,542)	$ (155,553)	1	1	0
2008	(534,826)	618,829	247,532	(163,529)	3	1	2
2009	(6,786,764)	623,088	(2,465,470)	(3,698,206)	6	3	3
2010	(5,890,543)	1,636,861	(1,701,473)	(2,552,209)	6	4	2
2011	(5,127,172)	5,042,040	(34,053)	(51,079)	6	3	3
2012	(1,688,610)	7,574,810	2,354,480	3,531,720	6	3	3

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Fiscal Year	Gross Deficit	Gross Surplus	CalOptima Share (40%)	Group Share (60%)	Number of SRGs Total	In Deficit	In Surplus
One-Time Revenue		17,233,958	12,917,452	4,316,506	6	3	3
2013	(1,568,113)	10,019,190	3,372,857	5,078,220	6	1	5
2014	-	57,808,875	23,123,550	34,685,325	7	0	7
2015	-	358,004,843	143,201,937	214,802,906	7	0	7
2016	-	403,276,602	161,310,641	241,965,961	7	0	7
2017	-	296,584,737	118,633,895	177,950,842	7	0	7
2018	-	110,844,053	44,337,621	66,506,432	5	0	5
2019	-	97,342,701	38,937,080	58,405,621	5	0	5
2020	-	52,735,299	21,094,120	31,641,179	5	0	5
	$(22,325,123)	$ 1,419,345,886	$ 564,756,627	$ 832,264,137			

Note: IBNR is calculated based on the paid claims experience.

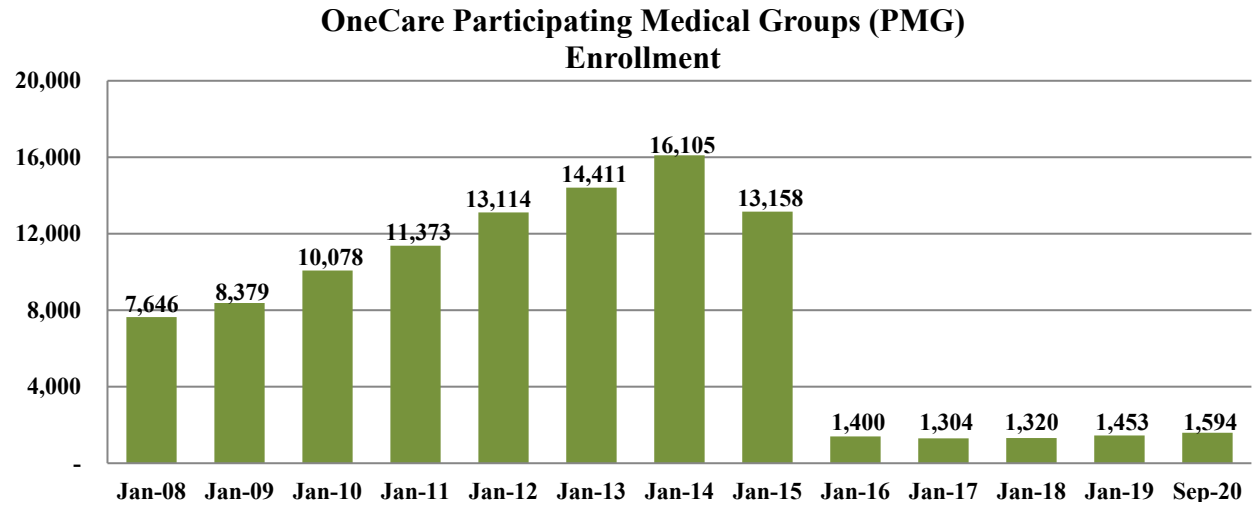
OneCare: As of September 30, 2020, OneCare has eight (8) Participating Medical Groups (PMGs).

Effective Dates:

- AMVI/Prospect – October 2005
- Talbert and Monarch – October 2005
- Noble – December 2012
- Family Choice – October 2005
- AltaMed – August 2008
- Arta and UCMG – January 2013

Enrollment

Overall enrollment decrease due to transitioning of members from OneCare to OneCare Connect in January 2016.



Pool Performance

Calendar Year	Gross Deficit	Gross Surplus	CalOptima Share (50%)	Group Share (50%)	Total	In Deficit	In Surplus
2005	$(14,225)	$163,580	$67,920	$81,435	4	1	3

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Calendar Year	Gross Deficit	Gross Surplus	CalOptima Share (50%)	Group Share (50%)	Total	In Deficit	In Surplus
2006	-	15,004,268	7,502,134	7,502,134	5	0	5
2007	(21,936)	3,759,945	1,859,817	1,878,193	8	2	6
2008	(491,522)	3,919,765	1,591,331	1,836,913	8	2	6
2009	(313,648)	5,643,332	2,525,933	2,803,751	9	2	7
2010	(566,705)	4,769,324	1,892,617	2,310,002	8	3	5
2011	-	9,406,281	4,703,141	4,703,141	8	0	8
2012	(433,732)	7,325,076	3,305,088	3,586,257	11	2	9
2013	(1,949,544)	11,124,918	4,015,560	5,159,814	13	2	11
2014	(3,485,139)	10,050,507	1,962,394	4,602,974	13	3	10
2015	(154,268)	10,372,797	5,050,405	5,168,124	8	1	7
2016	(508,749)	379,472	(288,034)	158,757	8	3	5
2017	(310,790)	360,774	(110,282)	160,266	8	4	4
2018	(677,070)	904,199	(178,235)	405,364	8	3	5
2019	(387,446)	325,762	(189,341)	127,656	8	4	4
2020Q2	(44,535)	587,601	269,343	273,723	8	2	6
	$ (9,359,305)	$ 84,097,601	$ 33,979,791	$ 40,758,503			

Note: Group share deficit limited to $5.00 PMPM. Estimated RAPS recoupment excluded from the above data.

OneCare Connect: As of September 30, 2020, OneCare Connect has six (6) Shared Risk Groups (SRGs).

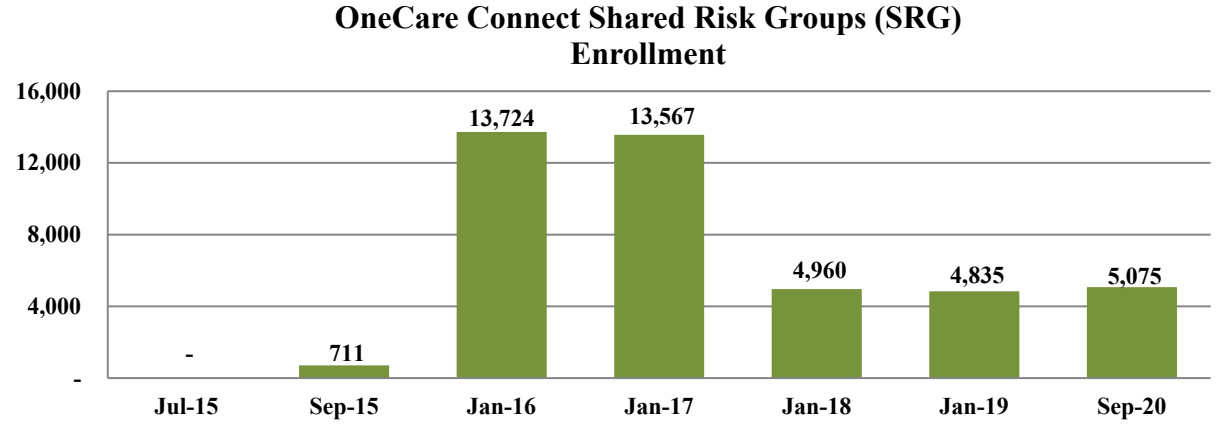
Effective Dates:

- Noble – July 2015
- UCMG – July 2015
- AltaMed – July 2015
- Monarch* – July 2015 to January 2017
- FCMG – January 2016
- Talbert – January 2016
- Arta Western – January 2016
- Prospect* – July 2015 to June 2017

** Monarch became an HMO group in February 2017. Prospect became an HMO group in July 2017.*

Enrollment

SRGs are serving approximately 5,100 members. It represents about 35% of CalOptima's OneCare Connect enrollment.



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Pool Performance

Calendar Year	Gross Deficit	Gross Surplus	CalOptima Share (50%)	Group Share (50%)	Total	In Deficit	In Surplus
2015	(261,199)	224,558	(121,755)	85,114	5	2	3
2016	(761,826)	20,200,150	9,372,994	10,065,330	8	1	7
2017	(1,020,988)	8,976,815	3,592,320	4,363,508	8	2	6
2018	-	9,926,822	4,963,411	4,963,411	6	0	6
2019	(125,349)	6,939,443	3,378,423	3,435,672	6	1	5
2020Q3	-	9,266,943	4,633,471	4,633,471	6	0	6
	$ (2,169,362)	$ 55,534,731	$ 25,818,864	$ 27,546,505			

Note: Group share deficit limited to $5.00 PMPM. QI withhold reimbursement and estimated RAPS recoupment excluded from the above data.

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Financial Summary - Whole Child Model

September 2020

Board of Directors' Finance and Audit Committee Meeting

November 19, 2020

Nancy Huang

Chief Financial Officer

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Whole Child Model Enrollment: FY 2020-21

September 2020 MTD

WCM enrollment was 13,020 members

- Actual higher than budget 1,088 or 9.1% due to restated prior year enrollment

September 2020 YTD

WCM enrollment was 31,359 members

- Actual lower than budget 4,437 or 12.4%

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Whole Child Model Revenue: FY 2020-21

September 2020 MTD

WCM revenue was $25.3 million

- Actual higher than budget $1.6 million or 6.8%
  - Favorable volume related variance of $2.2 million related to prior year restated enrollment
  - Unfavorable price related variance of $0.5 million

September 2020 YTD

WCM revenue was $61.3 million

- Actual lower than budget $9.7 million or 13.6%
  - Unfavorable volume related variance of $8.8 million
  - Unfavorable price related variance of $0.9 million

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Whole Child Model Medical Expenses: FY 2020-21

September 2020 MTD

WCM expenses were $19.5 million

- Actual lower than budget $4.0 million or 17.2%
  - Unfavorable volume related variance of $2.1 million
  - Favorable price related variance of $6.2 million
    - Facilities Claims expense favorable variance of $4.1 million
    - Prescription Drugs expense favorable variance of $2.1 million
    - Professional Claims expense favorable variance of $1.6 million
    - Offset by:
      - MLTSS expense unfavorable variance of $1.0 million
      - Provider Capitation expense unfavorable variance of $0.6 million

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Whole Child Model Medical Expenses: FY 2020-21 (cont.)

September 2020 YTD

WCM expenses were $61.4 million

- Actual lower than budget $9.8 million or 13.7%
  - Favorable volume related variance of $8.8 million
  - Favorable price related variance of $0.9 million
    - Facilities Claims expense favorable variance of $6.4 million
    - Prescription Drugs expense favorable variance of $4.7 million
    - Professional Claims expense favorable variance of $2.9 million
    - Offset by:
      - Provider Capitation unfavorable variance of $9.4 million
      - MLTSS expense unfavorable variance of $3.7 million

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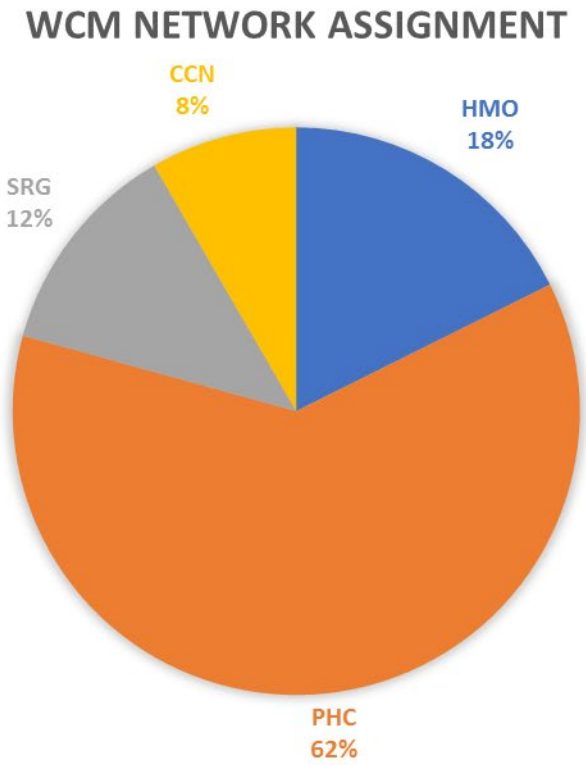
Enrollment Distribution: FY 2020-21



Note: % calculated based on YTD MM average

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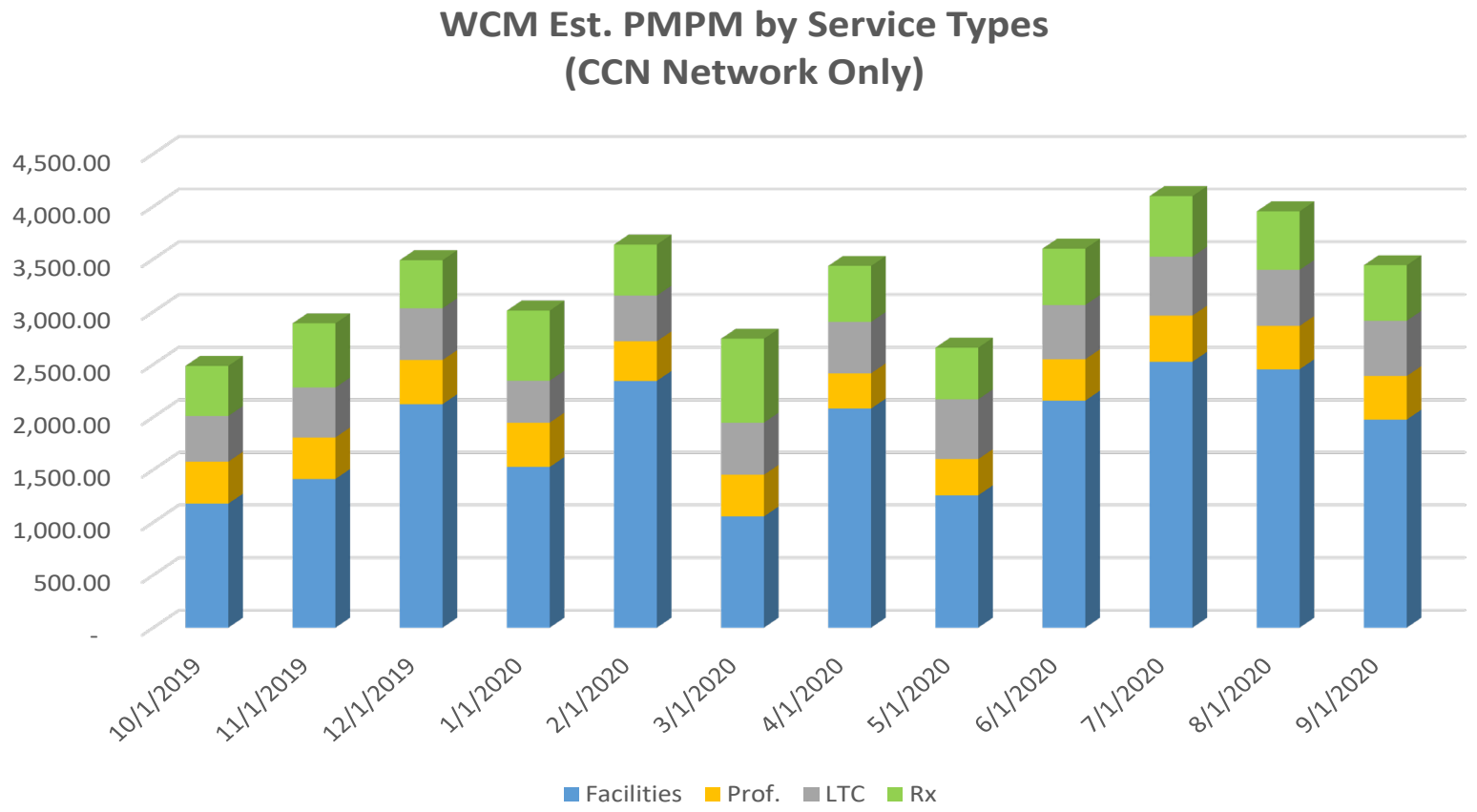
WCM Monthly Expenditures by Service Types



Note: Estimated PMPM for last 12 months are based on CCN network experience and includes IBNR

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Whole Child Model Financial Highlights: September 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
13,020	**11,932**	**1,088**	**9.1%**	**Member Months**	**31,359**	**35,796**	**(4,437)**	**(12.4%)**
				Revenues				
25,256,176	23,647,970	1,608,206	6.8%	Capitation Revenue	61,287,137	70,943,908	(9,656,771)	(13.6%)
25,256,176	**23,647,970**	**1,608,206**	**6.8%**	**Total Operating Revenue**	**61,287,137**	**70,943,908**	**(9,656,771)**	**(13.6%)**
				Medical Expenses				
10,061,928	8,646,107	(1,415,821)	(16.4%)	Provider Capitation	32,078,659	25,938,323	(6,140,336)	(23.7%)
1,995,805	5,563,497	3,567,692	64.1%	Facilities Claims	8,267,484	16,733,439	8,465,955	50.6%
991,707	2,349,720	1,358,013	57.8%	Professional Claims	3,358,510	7,179,946	3,821,436	53.2%
2,101,998	1,044,409	(1,057,589)	(101.3%)	MLTSS	6,487,480	3,161,416	(3,326,064)	(105.2%)
4,059,085	5,614,688	1,555,603	27.7%	Prescription Drugs	10,306,449	17,090,262	6,783,813	39.7%
295,108	349,681	54,573	15.6%	Medical Management	878,910	1,078,693	199,783	18.5%
19,604	-	(19,604)	0.0%	Reinsurance & Other	41,270	-	(41,270)	0.0%
19,525,235	**23,568,102**	**4,042,867**	**17.2%**	**Total Medical Expenses**	**61,418,762**	**71,182,079**	**9,763,317**	**13.7%**
5,730,941	**79,868**	**5,651,073**	**7075.5%**	**Gross Margin**	**(131,626)**	**(238,171)**	**106,545**	**44.7%**
928,279	**869,170**	**(59,109)**	**(6.8%)**	**Administrative Expenses***	**2,308,691**	**2,672,462**	**363,771**	**13.6%**
4,802,662	**(789,302)**	**5,591,964**	**708.5%**	**Change in Net Assets**	**(2,440,317)**	**(2,910,633)**	**470,317**	**16.2%**
77.3%	***99.7%***	***22.4%***	***22.4%***	***Medical Loss Ratio***	***100.2%***	***100.3%***	***0.1%***	***0.1%***
3.7%	***3.7%***	***(0.0%)***	***(0.0%)***	***Admin Loss Ratio***	***3.8%***	***3.8%***	***(0.0%)***	***(0.0%)***

***Note: Administrative Expenses presented are based on budgeted percentages**

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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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Financial Summary - Health Homes Program

September 2020

Board of Directors' Finance and Audit Committee Meeting

November 19, 2020

Nancy Huang

Chief Financial Officer

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Health Homes Program Background

- Health Homes Program (HHP)
  - Serves eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions
  - Improves care coordination and program integration

- HHP Implementation
  - Phase I began January 1, 2020, for members with chronic conditions only
  - Phase II began July 1, 2020, for members with Serious Mental Illness (SMI), with or without chronic conditions

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HHP Enrollment: FY 2020-21

September 2020 MTD

HHP enrollment was 395

- Actual lower than budget 1,671 or 80.9%

September 2020 YTD

HHP enrollment was 1,244

- Actual lower than budget 3,539 or 74.0%

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HHP Revenue: FY 2020-21

September 2020 MTD

HHP revenue was $207.0 thousand

- Actual lower than budget $875.1 thousand or 80.9%
  - Unfavorable volume related variance of $875.2 thousand
  - Favorable price related variance of $103

September 2020 YTD

HHP revenue was $652.3 thousand

- Actual lower than budget $1.9 million or 74.0%
  - Unfavorable volume related variance of $1.9 million
  - Favorable price related variance of $731

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HHP Medical Expenses: FY 2020-21

September 2020 MTD

HHP expenses were $190.3 thousand

- Actual lower than budget $891.8 thousand or 82.4%
  - Favorable volume related variance of $875.2 thousand
  - Unfavorable price related variance of $16.6 thousand

September 2020 YTD

HHP expenses were $623.2 thousand

- Actual lower than budget $1.9 million or 75.1%
  - Favorable volume related variance of $1.9 million
  - Favorable price related variance of $28.4 thousand

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HHP Financial Highlights: September 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
395	**2,066**	**(1,671)**	**(80.9%)**	**Member Months**	**1,244**	**4,783**	**(3,539)**	**(74.0%)**
				Revenues				
207,006	1,082,080	(875,074)	(80.9%)	Capitation Revenue	652,343	2,505,505	(1,853,161)	(74.0%)
207,006	**1,082,080**	**(875,074)**	**(80.9%)**	**Total Operating Revenue**	**652,343**	**2,505,505**	**(1,853,161)**	**(74.0%)**
				Medical Expenses				
70,810	596,677	525,868	88.1%	Provider Capitation	275,332	1,363,156	1,087,824	79.8%
11,310	-	(11,310)	0.0%	Professional Claims	23,360	-	(23,360)	0.0%
108,181	485,402	377,221	77.7%	Medical Management	324,543	1,142,349	817,806	71.6%
190,301	**1,082,080**	**891,779**	**82.4%**	**Total Medical Expenses**	**623,235**	**2,505,505**	**1,882,270**	**75.1%**
16,705	**-**	**16,705**	**100%**	**Gross Margin**	**29,108**	**-**	**29,108**	**100%**
91.9%	***100.0%***	***8.1%***	***8.1%***	***Medical Loss Ratio***	***95.5%***	***100.0%***	***4.5%***	***4.5%***

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CalOptima A Public Agency

Our Mission

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

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Board of Directors' Finance and Audit Committee Meeting
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Quarterly Reinsurance Report

Summary of Reinsurance Payments Made by CalOptima to Contracted Medi-Cal Providers for Policy Years (PY) 2019, 2020 and 2021

Reinsurance is an after-the-fact payment mechanism CalOptima provides that is intended to mitigate the financial impact of catastrophic claims on participating providers. CalOptima's policy allows participating providers through December 31st following the policy year end (i.e., June 30) to submit all reinsurance claims. CalOptima issues payment to providers within forty-five (45) business days after the quarter's end.

The figures reported below reflect the estimated results for PY 2019, PY 2020 and PY 2021, as of September 30, 2020.

	PY 2019	PY 2020	PY 2021
YTD Budgeted Reinsurance Expense @ 9/30/20	$5,016,633	$12,740,978	$1,474,638
Reinsurance paid through 9/30/20	$(2,819,558)	$(1,802,175)	$(0)
Estimated Reinsurance Accrual @ 9/30/20	$(1,346,457)	$(2,570,484)	$(1,170,000)
Total Estimated Reinsurance Expense @ 9/30/20	$(4,166,015)	$(4,372,658)	$(1,170,000)
YTD Budgeted Savings/(Deficit) @ 9/30/20	$850,618	$8,368,320	$304,638

The total estimated liability as of September 30, 2020, is $5.1 million.

The policy thresholds are $17,000 for Professional and $150,000 for Hospital; coinsurance level is 20%.

Policy Years:
PY 2019 = Fiscal Year 2019 (July 1, 2018, through June 30, 2019)
PY 2020 = Fiscal Year 2020 (July 1, 2019, through June 30, 2020)
PY 2021 = Fiscal Year 2021 (July 1, 2020, through June 30, 2021)

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Quarterly Health Network Financial Update

On a quarterly basis, CalOptima reviews the unaudited financial statements of the capitated Physician Groups, Hospitals and HMOs that comprise CalOptima's Health Networks. After internal review, CalOptima's financial staff makes a determination as to whether the capitated entity has the ability to assume the risk of a capitated contract.

CalOptima reviewed the unaudited financial statements for each Health Network entity for the period ending June 30, 2020.

Results of the June 30, 2020, Financial Review

	Physician Groups	Hospitals	HMOs
Total	8	3	4
Passed Review	8	3	4
Failed Review	0	0	0
On Notice	0	0	0
Did Not Submit Statements	0	0	0

Note 1: Physician Groups and Hospitals must pass the following tests:

a) Current Ratio - must be ≥ 1.0
b) Tangible Net Equity - must be ≥ 1.0
c) Cash to Claims Ratio - must be ≥ 0.75

Note 2: HMOs must pass the following test:

a) Tangible Net Equity - Greater of $1M, % of premium revenues, or % of healthcare expenses

Note 3: Financial Security Reserves:

a) Medi-Cal, OneCare, and OneCare Connect Total Current Balance = $18.3M

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Contingency Contract Report

CalOptima Active Contingency Contracts	Q1 FY21	invoiced as of 9/30/2020												
Quarterly & Annual Medical Cost Savings or Additional Revenue and Fees Paid														
	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	Qt	FY19	FY20	FY21
	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total		Total	Total	Qtr 1	Total
MEDICAL COST														
HMS - Coordination of Benefits i.e. ensure Medi-Cal is the payor of last resort - (expires 5/14/2023)														
Savings	$ 1,189,393	$ 2,811,751	$ 1,937,748	$ 2,565,125	$ 2,346,048	$ 1,444,807	$ 3,336,995	$ 3,954,564	$ 4,067,881	$ 5,864,338		$ 4,863,112	$ 2,435,998	$ 709,570	$ 709,570
Fee	$ 297,348	$ 702,938	$ 484,359	$ 641,281	$ 586,762	$ 361,202	$ 794,557	$ 909,550	$ 935,613	$ 1,348,798		$ 1,118,516	$ 560,280	$ 169,144	$ 169,144
Net Savings	$ 892,045	$ 2,108,813	$ 1,453,389	$ 1,923,843	$ 1,759,286	$ 1,083,605	$ 2,542,438	$ 3,045,014	$ 3,132,268	$ 4,515,540		$ 3,744,596	$ 1,875,718	$ 540,426	$ 540,426
Cotiviti (Verscend/Verisk/HCI) - Claims review for appropriate billing - (expires 10/07/2021)														
Savings	$ 164,913	$ 2,397,831	$ 3,385,560	$ 2,517,497	$ 2,817,113	$ 2,647,841	$ 3,562,859	$ 3,524,096	$ 2,690,597	$ 2,571,045		$ 4,482,782	$ 8,804,673	$ 1,813,984	$ 1,813,984
Fee	$ 37,165	$ 483,209	$ 691,554	$ 559,136	$ 595,632	$ 727,333	$ 1,371,137	$ 638,601	$ 393,455	$ 580,345		$ 932,051	$ 1,695,000	$ 353,727	$ 353,727
Net Savings	$ 127,748	$ 1,914,622	$ 2,694,006	$ 1,958,361	$ 2,221,482	$ 1,920,508	$ 2,191,722	$ 2,885,495	$ 2,297,143	$ 1,990,700		$ 3,550,731	$ 7,109,674	$ 1,460,257	$ 1,460,257
Socrates - Third party liability - (expires 12/31/2020)														
Savings	-	-	13,783	244,770	53,141	$ 3,108	N/A	$ 219,258	N/A	N/A		N/A	$ 18,864	$ 4,758	$ 4,758
Fee	-	-	3,446	61,223	13,285	$ 777	N/A	$ 54,815	N/A	N/A		N/A	$ 4,716	$ 1,189	$ 1,189
Net Savings	-	-	10,338	183,548	39,856	2,331		164,443					$ 14,148	$ 3,568	$ 3,568
Varis - Facility claims forensic review - (expires 9/25/2021)														
Savings	-	-	-	-	-	-	-	-	-	-		$ 3,057,075	$ 3,929,330	$ 488,819	$ 488,819
Fee	-	-	-	-	-	-	-	-	-	-		$ 764,269	$ 982,332	$ 122,205	$ 122,205
Net Savings	-	-	-	-	-	-	-	-	-	-		$ 2,292,806	$ 2,946,997	$ 366,614	$ 366,614
OptumInsight - Credit balance recovery - (expires 12/31/2021)														
Savings	-	-	-	$ 76,715	$ 26,203	$ 30,246	N/A	$ 44,834	$ 404,824	$ 154,308		$ 416,557	$ 125,155	$ 78,846	$ 78,846
Fee	-	-	-	$ 9,206	$ 3,144	$ 3,630	N/A	$ 5,380	$ 48,579	$ 18,517		$ 49,987	$ 15,019	$ 9,462	$ 9,462
Net Savings	-	-	-	$ 67,509	$ 23,059	$ 26,616		$ 39,454	$ 356,245	$ 135,791		$ 366,570	$ 110,136	$ 69,384	$ 69,384
TOTAL														
Savings	$ 1,354,306	$ 5,209,582	$ 6,224,285	$ 6,522,317	$ 8,705,661	$ 7,850,202	$ 23,438,635	$ 11,249,969	$ 11,232,038	$ 9,823,995		$ 12,819,526	$ 15,314,020	$ 3,095,977	$ 3,095,977
Fee	$ 334,514	$ 1,186,146	$ 1,446,206	$ 1,618,527	$ 2,240,427	$ 2,210,357	$ 4,173,694	$ 2,345,328	$ 2,518,002	$ 2,256,236		$ 2,864,823	$ 3,257,346	$ 655,726	$ 655,726
Net Savings	$ 1,019,792	$ 4,023,436	$ 4,778,079	$ 4,903,791	$ 6,465,234	$ 5,639,844	$ 19,264,941	$ 8,904,640	$ 8,714,036	$ 7,567,760		$ 9,954,704	$ 12,056,674	$ 2,440,250	$ 2,440,250
REVENUE														
Human Arc - SSI Outreach & Aid Code Conversion - (expires 6/30/2021)														
Capitation Revenue				$ 1,723,235	$ 4,526,183	$ 5,231,987	$ 6,539,353	$ 7,782,145	$ 9,281,708	$ 11,188,354		$ 12,961,036	$ 15,343,180	$ 4,222,015	$ 4,222,015
Fee				$ 501,700	$ 345,100	$ 285,650	$ 232,092	$ 301,556	$ 360,018	$ 350,084		$ 513,800	$ 567,000	$ 105,000	$ 105,000
Total Net Revenue	-	-	-	$ 1,221,535	$ 4,181,083	$ 4,946,337	$ 6,307,261	$ 7,480,589	$ 8,921,690	$ 10,838,270		$ 12,447,236	$ 14,776,180	$ 4,117,015	$ 4,117,015

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